December, 1956
Volume 55
Number 12

The Journal

of the Michigan State Medical Society

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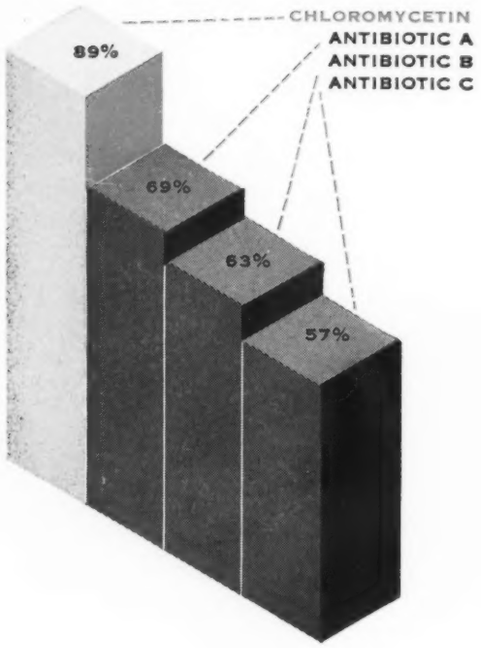

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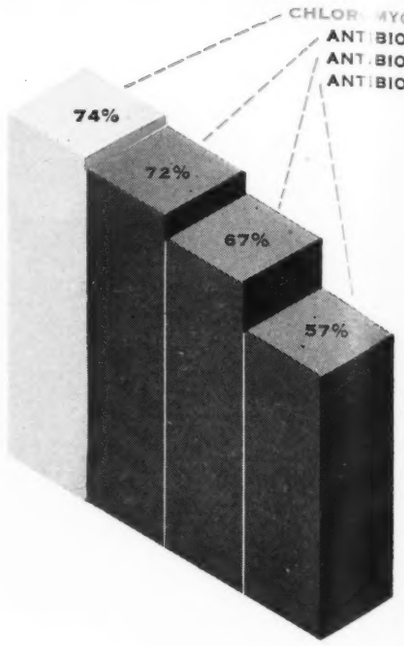

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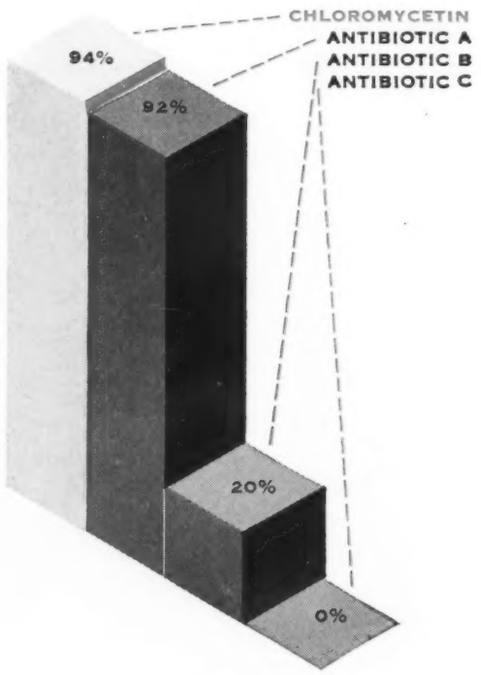

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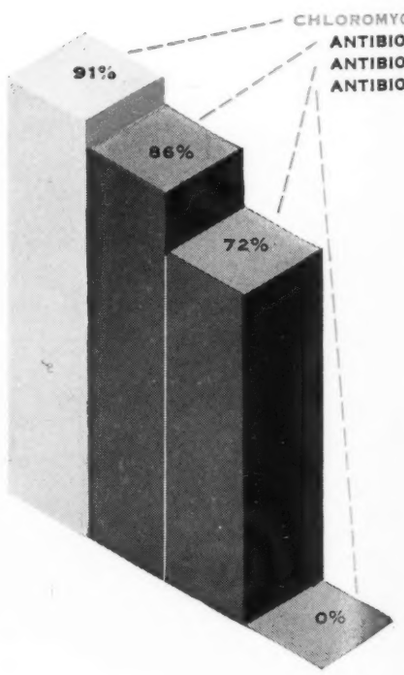

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(153-193 STRAINS)

THE JOURNAL
of the Michigan State Medical Society

VOLUME 55 DECEMBER, 1956 NUMBER 12

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THE JOURNAL
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* * *

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 17, 1956

- **The monthly financial report** and bills payable were presented and approved.
- **Officers Night Banquet:** Report on banquet held September 26, 1956 (during MSMS Annual Session), resulted in a motion that the Officers Night Banquet be repeated but that the Biddle Lecture be scheduled as a day presentation on Wednesdays at future MSMS Annual Sessions, with details for the 1957 Banquet to be developed by the Executive Directors and Public Relations Council for presentation to The Council.
- **The Committee to meet with UAW-CIO:** The President was authorized to appoint a committee of MSMS representatives to meet with the President and other officers of the UAW-CIO to discuss medical problems.
- **Report on October 19 meeting re medical licensure** resulted in motion that "The Council approves the present medical licensure legislation in Michigan."
- **W. S. Jones, M.D.,** of Menominee, a member of the Governor's Study Commission on Public Health, relayed the Commission's request that MSMS present its views concerning public health matters at the October 26 meeting of the Commission in Lansing. The invitation was accepted.
- **Appointments:** R. W. Teed, M.D., Ann Arbor, and A. B. Gwinn, M.D., Hastings, were appointed Chairman and Vice-Chairman respectively of the Public Relations Committee; the Committee on Study of Fee Schedules for Michigan Medical Service was reappointed in toto, with L. W. Hull, M.D., Detroit, as Chairman; Committee on Study of Prevention of Highway Accidents was appointed as follows: J. R. Rodger, M.D., Bellaire, Chairman, G. H. Agate, M.D., Lansing; H. E. DePree, M.D., Kalamazoo; J. M. Dorsey, M.D., Highland Park; H. F. Falls, M.D., Ann Arbor; A. Z. Howard, M.D., Detroit; H. T. Johnson, M.D., Lansing; R F. Powers, M.D., Saginaw; C. L. Straith, M.D., Detroit, and H. J. Meier, M.D., Coldwater, Advisor. James W. Hubly, M.D., Battle Creek, and Wm. A. Irwin, M.D., of Detroit, were appointed as MSMS representatives to the Michigan Cancer Co-ordinating Committee. E. G. Merritt, M.D., Detroit, and J. D. Miller, M.D., Grand Rapids, were appointed as MSMS representatives to meet with representatives of the State Pharmaceutical Board on dispensing of drugs.
- **County Secretaries—Public Relations Seminar:** The theme and program of the January, 1957 County Secretaries-Public Relations Seminar was presented and approved.
- **Resolutions** as adopted by the Section on Public Health and Preventive Medicine on September 26, (at Annual Session) were presented:
  - (a) Endorsing fluoridation of public water supply, which was endorsed by the Executive Committee;
  - (b) Recommending that a full-time Chair of Preventive Medicine and Public Health be established at each of the two medical schools located in Michigan, which was endorsed by the Executive Committee pro-

(Continued on Page 1418)

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physician groups in Michigan, follows:

1957

January 16-18	Michigan Rural Health Conference	East Lansing
January 23-25	Annual Meeting of the MSMS Council, Sheraton-Cadillac Hotel	Detroit
January 25-27	MSMS County Secretaries-Public Relations Seminar, Sheraton-Cadillac Hotel	Detroit
March 13-15	Michigan Clinical Institute, Sheraton-Cadillac Hotel	Detroit
Spring	MSMS Postgraduate Extramural Courses	Statewide
April 17	Genesee County Medical Society, Twelfth Annual Cancer Day	Flint
May 5-10	Sixth International Congress of Otolaryngology	Washington, D. C.

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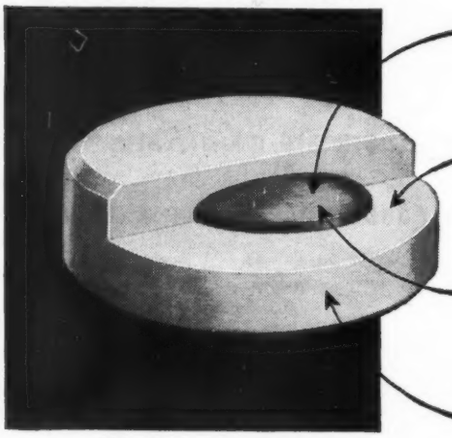

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Myositis
Fibrositis
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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 1414)

vided such chairs are filled only by doctors of medicine;

(c) Requesting substantial representation from the Public Health and Preventive Medicine Section on the MSMS Committee on Preventive Medicine, which resolution was disapproved because the MSMS By-laws specifically designate the composition of this particular committee (chairmen of the scientific committees of the Society).

- **Section Attendance at September, 1956, Annual Session:** General Practice 185, Pathology 110; Gastroenterology-Proctology 105, Nervous and Mental 100, Urology, 96, Anesthesiology, 75, Public Health and Preventive Medicine 61; Obstetrics & Gynecology 54; Ophthalmology 50; Occupational Health 40; Dermatology & Syphilology 31; Pediatrics 25; Medicine 20; Otolaryngology 19; Radiology 14.
- **1957 Testimonial Luncheon for Michigan M.D.'s** who are Presidents of national medical and health societies—the report and plans of Chairman G. B. Saltonstall, M.D., of Charlevoix, was approved.
- **Gold Medal Award:** The Council approved the creation of a Gold Medal Award for scientific achievement in this state, to be presented at the testimonial luncheon on March 14, 1957, during the Michigan Clinical Institute.
- **Ralph W. Shook, M.D.,** was authorized to attend organizational meeting of the American Association of Medical Assistants in Milwaukee.
- **C. Robert Dean, M.D.,** Detroit, was nominated for the President Physician's Award, for outstanding contributions to the handicapped and their employment.
- **K. W. Toothaker, M.D.,** Lansing, and E. M. Vardon, M.D., Detroit, were nominated to the Governor as MSMS representatives to the Michigan Board of Nursing Advisory Council.
- **Council Committees for the year 1956-57,** including the four standing committees, were presented by Chairman Wiley and approved.
- **Progress report** on the Kopprasch case was presented by Legal Counsel Lester P. Dodd, Detroit.
- **Medicare Program:** Jay C. Ketchum, Executive Vice President of Michigan Medical Service, reported on the swift progress of this program implementing the federal law to supply medical care to servicemen's dependents; complete informational material on the medicare program will be sent to all MSMS members, as soon as the program has been firmed. D. Bruce Wiley, M.D., Utica, and W. B. Harm, M.D., Detroit, were authorized to attend the Medicare Conference, Washington, D. C., October 24, to negotiate the contract on behalf of MSMS.
- **The monthly report of Rheumatic Fever Coordinator** Leon DeVel, M.D., was presented and received.
- **The Public Relations Counsel** presented the following matters: (a) Conference of Health Professionals, a meeting preceding Michigan Rural Health Conference, January, 1957; (b) Farm-City Week; (c) Preparing material for Michigan Employment Security Commission on training and work of a doctor of medicine; and (d) that President Walls, Detroit, Secretary L. Fernald Foster, Bay City, and Herbert Estes of Ann Arbor (President of Michigan Health Council) will speak at the Detroit Economic Club in Detroit on March 4.
- **Committee Reports:** The following were reviewed: (a) Advisory Committee of Past Presidents, meeting of September 27; (b) Joint Meeting of National Defense and Rural Medical Service Committees, October 10; and (c) Progress Report from Maternal Health Committee Chairman Francis Jones, M.D., Lansing.

EFFECTIVE LIAISON BY A COUNTY MEDICAL SOCIETY

C. D. Selby, M.D., Port Huron, Secretary of St. Clair County Medical Society, reports that the St. Clair County Medical Society has made special efforts this year to improve relationships with the public, the voluntary health and welfare agencies and those professional groups whose interests are concerned with the practice of medicine.

In the spring, the society met with the pharmacists of St. Clair County, and so many common objectives came out of that meeting that a joint committee was created to represent the two groups. This committee was charged with the development of common policies for guidance of physicians and pharmacists in affairs related to public health and preventive medicine.

On October 10, 1956, members of the Lambton County Medical Society of Ontario, Canada, which includes the city of Sarnia, met with the St. Clair County Medical Society at the Black River Country Club in Port Huron. The program, arranged by the local doctors, was as follows:

1. "Management of Strabismus"
   GLENN E. MOHNEY, M.D.
2. "Use of Intra-Medullary Nails in Fractures of the Femur"
   CHARLES O. TOWNLEY, M.D.
3. "Hypertension in Relation to Unilateral Kidney Disease"
   R. S. BAILEY, M.D.

On November 13, local members of the Bar Association met with the St. Clair County Medical Society and discussed matters of concern to these

(Continued on Page 1422)

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ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

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EFFECTIVE LIAISON BY A COUNTY MEDICAL SOCIETY

(Continued from Page 1418)

two groups. Some matters in the field of forensic medicine were clarified.

The St. Clair County Medical Society now has special medical advisory committees to work with the Community Chest, National Foundation for Infantile Paralysis, Boy Scouts, Girl Scouts, Red Cross, Chamber of Commerce, and Port Huron Junior College.

AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The thirty-fifth annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 8-13, 1957, inclusive, at Hotel Statler, Los Angeles. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award annually a prize for an essay on any subject relating to physical medicine and rehabilitation. The contest, while open to anyone, is primarily directed to medical students, interns, residents, graduate students in the pre-clinical sciences and graduate students in physical medicine and rehabilitation.

Full information may be obtained by writing to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

ANTIDIABETIC DRUGS

Eli Lilly and Company has announced the suspension of the fifteen-month clinical trial of carbutamide, or BZ-55. Carbutamide is a sulfonamide derivative which controls many cases of diabetes when given by mouth.

In a statement, Dr. Kenneth G. Kohlstaedt, director of the clinical research division, said:

"We have communicated this decision to some 2,900 physicians who have been testing carbutamide in more than 10,000 patients. We are grateful to these physicians and to scientists who have participated in what we believe is the most intensive study of a new compound undertaken to date by a pharmaceutical house.

"Our search for a safe oral antidiabetes compound which will relieve certain, selected diabetics of the necessity for daily Insulin injections is continuing undiminished. In fact we already have other compounds under study which we hope will offer more promise in offsetting the pancreatic defect that underlies diabetes without involving risks unacceptable in wide-scale treatment.

"Discontinuing use of the drug involves no danger to the 10,000 patients who have been controlling their diabetes with it. They may safely return to their former method of control.

"We are not unmindful of the fact that 40,000 patients in Germany have taken carbutamide without any serious side effects being reported by German investigators. Nor are we unmindful of the fact that in our own studies 95 per cent of those patients who are able to control their diabetes with carbutamide appear to be able to do so for months without untoward effects. However, among the other 5 per cent there have been a few serious side reactions to the drug which are identical to those experienced with other sulfa drugs.

"In view of these findings, and in full consideration that carbutamide is a drug of convenience rather than necessity, Eli Lilly and Company believes it is prudent to suspend the clinical trial pending further investigation. It appears to us that the risks of possible injury and perhaps long-term effects not yet established are greater than any short-term benefits which may seem to be derived from the drug.

"We deeply regret that this compound apparently does not meet the rigid requirements for a drug that must be taken throughout life. At the same time, we are grateful that the study of carbutamide was broad enough and thorough enough to uncover its limitations.

"In the early study of carbutamide in about 700 patients, diabetes experts reported to us that there were almost no serious side reactions to the drug. As carbutamide continued to 'look good,' we expanded all phases of the investigation. The clinical trial was increased to include more than 10,000 patients. It was only after the larger test was put into effect that adverse reports began to be heard from the field.

"We share the disappointment of many diabetics. They had hoped that carbutamide would be the long-sought answer to the need for an oral therapy. We had hoped that through the introduction of carbutamide in the United States we could add to our long list of contributions to diabetes therapy which began with the first commercial Insulin preparation in January, 1923."

VOLUNTARY HEALTH INSURANCE IN MICHIGAN

The number of people in Michigan who are covered by voluntary health insurance reached a new high by September 30, 1956, the Health Insurance Council has reported. The Council estimates that 6,200,000 persons were protected by some form of insurance designed to help pay hospital and doctor bills.

This figure, the Council said, is part of the continued growth of health insurance throughout the country, which was revealed last August in its tenth annual survey of the extent of voluntary health insurance coverage for 1955. The number of people covered by some form of health insurance in the nation today stands at the 110 million mark.

In releasing the findings of its survey, which is based on reports of insurance programs of

(Continued on Page 1426)

Cancer Comment

THE MICHIGAN CANCER CO-ORDINATING COMMITTEE

Cancer: annually responsible for the death of well over 200,000 Americans and the cause of untold pain and suffering in those who survive, is one of the major health problems of our time. Interest in an organized effort for the control of cancer, in which the Michigan State Medical Society played an active part, began in 1930 with the development of a "Cancer Week" program by the American Society for the Control of Cancer and the formation of a permanent committee on cancer control by the medical society.

The initial efforts of these groups were directed toward additional education of the medical profession concerning the importance of cancer and newspaper publicity to awaken the interest of the public. The following ten years saw much quickening of efforts of physicians and the volunteer workers of the American Society for the Control of Cancer with gradually developing liaison between these two groups. This liaison has been of utmost importance in fostering and further increasing the effectiveness of the fight against cancer.

Governmental health agencies, as well as other professional organizations, developed increasing interest in this problem and were invited to send representatives to the Cancer Control Committee. By 1945, the committee membership of twenty-six included representatives from the two Michigan Divisions of the American Cancer Society, the Michigan Department of Health and the Michigan State Dental Association.

Time does not permit the enumeration of the many projects conceived, implemented and completed by the co-operative activities of these groups, nor to tell of the impact of these efforts on the medical profession and the public at large.

Availability of increasing funds for cancer through the yearly campaigns of the American Cancer Society and annual contributions of the Federal Government to the state health departments made closer liaison and co-operation among all groups interested in this problem more vital if the most effective program for cancer control was to be developed and activated.

Consequently, in 1953, the President and the Council of the Michigan State Medical Society formally invited the two Michigan Divisions of the American Cancer Society, the Michigan Department of Health, the Michigan Health Officers Association and the Michigan State Dental Association to form a voluntary co-operative committee to better co-ordinate the activities of all groups interested in the eradication of cancer as a major health problem. This Michigan Cancer Co-ordinating Committee composed of fifteen lay and professional members was formally organized, reviewed the activities of the several organizations represented, and developed aims and objectives of its own.

Following this review and a further analysis of the several problems involved, the committee suggested the responsibilities of each of the six organizations in the attack on each problem. The most important problems considered were public education, improvement in the earlier diagnosis and treatment of cancer, statistics, professional education, research, organization and campaign. In developing an all-out program, it was further decided that there should be a regular (annual) review of the activities of the several organizations with criticisms and suggestions for continuation, change in emphasis or possible discontinuance of certain projects. All recommendations of the Michigan Cancer Co-ordinating Committee are subject to approval of the member organizations involved. It is hoped, however, that this committee will ultimately act in more than a purely advisory capacity and that additional agencies interested in cancer might be added to the representation.

Again, time does not permit recounting all of the activities of this group, but it is pertinent to mention some of the more important projects which have been carried over from the Cancer Control Committee and those developed by the Michigan Cancer Co-ordinating Committee in its three years of operation. For sake of time and space, these will be merely listed.

1. Revision, publication and distribution of the brochure, "The Story of Cancer for High Schools," which now approaches 14,000 distributed copies.
2. Sponsorship of an annual "Cancer Number" of THE JOURNAL of the Michigan State Medical Society, as well as development of a bimonthly "Cancer Comment" page in the same publication.
3. Creation and sponsorship of the annual "Michigan Cancer Co-ordinating Committee Lecture" at the Michigan Clinical Institute in Detroit on some phase of cancer for physicians.
4. Cosponsorship of an annual Cancer Conference for physicians and volunteer workers held in conjunction with the Leadership Training Conference of the Michigan Divisions of the American Cancer Society.
5. Development of liaison with many organizations including the Michigan Department of Public Instruction, the Michigan Education Association, the Michigan

(Continued on Page 1426)

THE MICHIGAN CANCER CO-ORDINATING COMMITTEE

(Continued from Page 1424)

Rural Health Conference and various nurses organizations, to the end that these groups will have speakers on their annual programs stressing the importance of cancer and methods by which teachers, high school and college students, nurses and others may be kept informed about new developments in this field. The committee is glad to furnish speakers on cancer subjects to any statewide organization.

6. Urging each county medical society in Michigan to devote at least one meeting annually to some phase of cancer and supplying speakers on these subjects when requested. So far thirty-eight speakers have been used.

7. Sponsorship of exhibits on cancer (including quackery) at various medical meetings, as well as the Michigan State Fair and other public events or conventions.

8. Encouragement of the greater use of the periodic health examination of well persons in the office of the family physician, to the end that many more cases of cancer will be discovered early enough so that more successful treatment can be carried out.

9. Development of minimum standards of cancer control activities for the member organizations, as well as other groups.

10. Acting as a clearing house, in co-operation wi the member organizations, for their publications, kin scopes, movies and information about quackery.

11. Publication of an annual report on cancer co trol activities in Michigan.

12. Encouragement of county medical societies an hospital medical staffs to develop "Cancer Registries."

Finally, the job is only begun. The outlook fo the future is excellent if we continue in the direc tion in which we started. The projects mentione above, as well as others already begun, will requir much more time, co-operative effort and liaison

In a sense, this is a preliminary statement o our activities and our aims. It is the sincere hop of the members of this committee that our effor will be an additional stimulus to closer co-opera tion and liaison, not only among the organization represented at this time, but also to other organi zations who may join us in the future, and in fac to all organizations and individuals interested i the earliest possible solution to the many facets o the perplexing problem of Cancer Control.

C. ALLEN PAYNE, M.D., *Chairma*

Michigan Cancer Co-ordinating Committe

YOU AND YOUR BUSINESS

VOLUNTARY HEALTH INSURANCE IN MICHIGAN

(Continued from Page 1422)

insurance companies, Blue Cross-Blue Shield and other health care plans, the Council went on to say that there were 5,869,000 persons covered by hospital expense insurance in Michigan as of December 31, 1955. This represents a gain of 495,000 over the 1954 total of 5,374,000 persons.

Surgical expense insurance, which helps to defray the cost of physicians' charges for operations rose to 5,610,000, as compared with 5,201,000 the year before, a gain of 409,000 persons.

The number of people protected by regular medical expense insurance, providing doctor visits for non-surgical care, during 1955 rose to 4,066,000 as against the previous year's figure of 2,915,000, reflecting an increase of 1,151,000 persons covered.

The Health Insurance Council, which is a federation of eight insurance associations representing 90 per cent of the accident and health insurance business, stated that this growth reflects the desire of the people of Michigan to help protect themselves against the cost of accident and illness.—(*Health Insurance Institute*)

TAX RULINGS WILL BENEFIT HOSPITAL AND DEFENSE AIDES

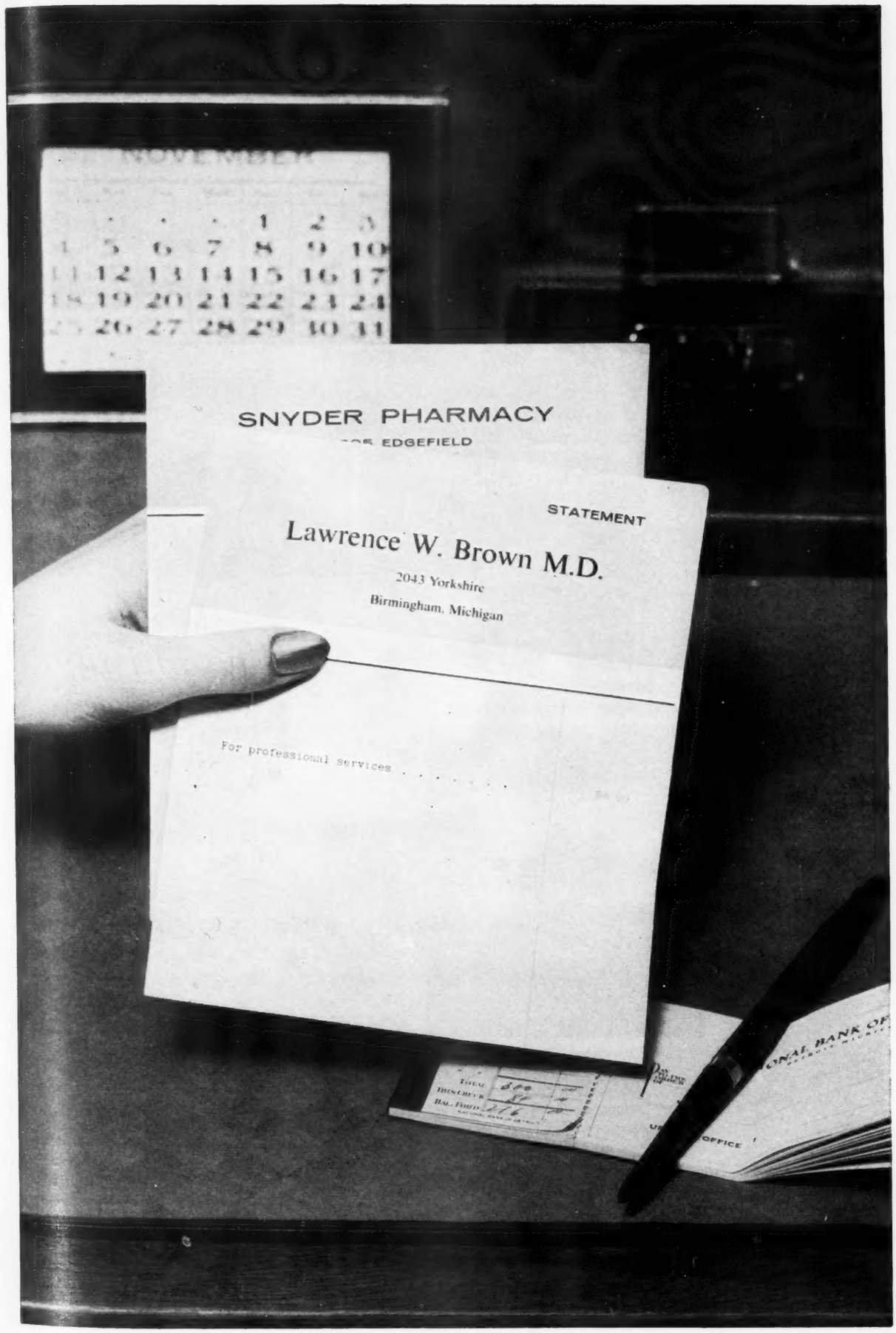
Two rulings pubished recently by Internal Revenue Service may have some effect in encouraging voluntary services as hospital aides and civil defense workers. In one lengthy opinion IRS holds that persons giving their services gratuitously to hospitals and churches may consider expenses of transportation and uniforms (cost and maintenance) as deductible charitable contributions. However, costs of meals are not included in this liberalization.

In the other ruling, travel and other expenses incidental to participation in civil defense activities are similarly held to constitute "contributions or gifts within the meaning of section 170 of the Internal Revenue Code of 1954 and are deductible in the manner and to the extent provided in such section."

Department of HEW's expanding program in health and welfare of the aging has recruited John B. Holden from Michigan State University as a specialist in adult education and aging in the Office of Education.

U. S. AID ASKED BY MAKERS OF SURGICAL INSTRUMENTS

American manufacturers of surgical instruments are in trouble. Logistics experts of Defense Department and Army, Navy and Air Force met with some of them recently at a special conference to discuss their difficulties, as outlined by their industry group, Manufacturers Surgical Trade Association. Main problem: Meeting competition of foreign manufacturers, notably the Germans, whose advantage of much lower labor costs enables them to market quality instruments at prices considerably below the American tags.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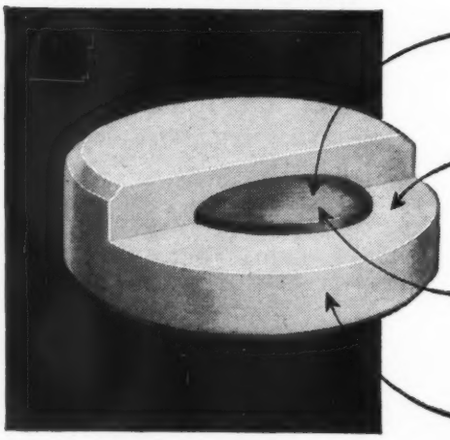

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PR REPORT

"THE MOVING FINGER WRITES; AND, HAVING WRIT . . . "

On November 6, in every voting precinct in the state, the "moving finger writ" and in so doing noted the election to the state legislature and Congress many of the incumbent office holders but added thirty-one newcomers.

The partisan make-up of the national and state legislative delegations changed little. Republicans and Democrats maintained the status quo in the State Senate, although six new members will replace retired or defeated members.

In Michigan's Congressional delegation, the Republicans gained one seat when Charles E. Chamberlain, the oldest (age thirty-nine) of the four freshmen-elect Congressmen out-campaigned Democrat Donald Hayworth, incumbent, in the Sixth District (comprising Ingham, Genesee, Livingston Counties). The only other change saw Republicans R. J. McIntosh, R. P. Griffin, and W. S. Broomfield, supplant former Republican members as the Democrats returned their other incumbents to Washington, D. C.

In the big (110 seat) Representative Hall in the Capitol at Lansing, twenty-one first-termers will take their oaths to uphold the constitution when the Legislature convenes on January 9. In these ranks, the Republicans picked up two seats formerly held by Democrats (Macomb, 3rd and Monroe) and elected a Republican from Plymouth to replace a Republican-turned-Independent.

Significant is the fact that although most of the professions are represented in these legislative bodies, there are no M.D.'s. Congratulations are in order to Russell H. Strange, M.D., Mt. Pleasant, whose son Russell H. Strange, Jr., of Clare, was elected a State Representative, the youngest member ever elected to the Michigan Legislature.

MICHIGAN RURAL HEALTH CONFERENCE TO FEATURE "PROFESSIONAL DAY"

A new feature of the Tenth Annual Michigan Rural Health Conference will be a Professional Day. The three-day conference will be held January 16, 17 and 18, 1957, at the Kellogg Center on the campus of Michigan State University.

(Continued on Page 1438)

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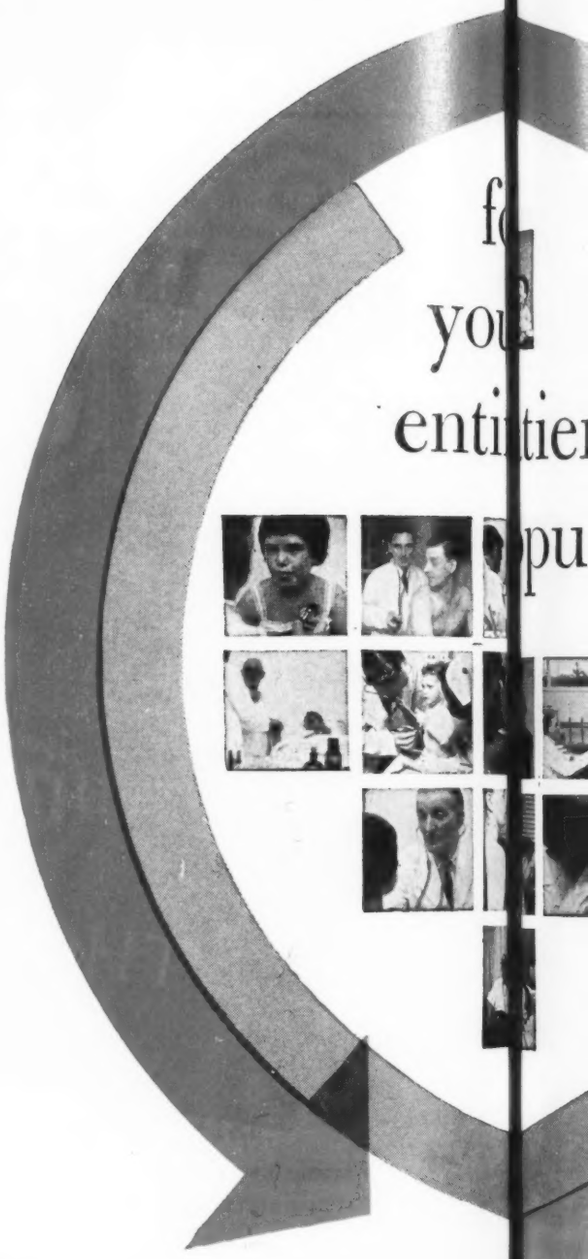

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MICHIGAN RURAL HEALTH CONFERENCE

(Continued from Page 1434)

The Planning Committee of the Rural Health Conference has set aside the first day of the meeting to be devoted entirely to scientific presentations by Doctors of Medicine and other professionals in the health field.

The speakers will develop their scientific papers around the theme of "fringe area" health problems—or those health problems which occur through the rapid expansion of the suburban areas as more and more people move out of the cities.

The problems include such subjects as sanitation, school health, water supply, and the fact that there are not enough doctors to serve the expanded community. Migratory labor in some areas is still another problem of "fringe areas."

The Council of MSMS has approved the expenses for one delegate from each County Medical Society.

PUBLIC RELATIONS—HERE TO STAY?

Organized public relations, fairly new to the medical scene, got a vote of confidence from physicians recently. A nationwide survey of doctors, commissioned by AMA, reveals that nine out of ten M.D.'s believe public relations should be an important or very important function of organized medicine.

PR programs, according to the doctors interviewed, make for better understanding, establish societies as the voice of the medical profession, and are an influence in preventing government medicine.

The survey reported that physicians have noted changes on both the national and state levels. They say they are aware of a greater volume of PR activity and a stepped-up pace in these efforts. Some say there is a changed philosophy and that those concerned with public relations seem to be more alert and trying harder to do a good job. They cite TV and radio programs, articles and publications, and a better press as specific indications of improved PR. A better public reaction to the profession is also noted.

The go-ahead signal for continued public relations efforts was also given in survey results. Today's physicians evidently are well aware that public relations is no stop-gap device to secure specific ends—but a long-range public service and educational-type program to build a foundation of understanding and good will.

Esophageal cancer is rarely diagnosed early.

* * *

The patient with esophageal cancer is normally dead within five years, regardless of treatment.

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AMA Washington Letter

THE MONTH IN WASHINGTON

Federal health and medical spending for all agencies of government this fiscal year is expected to reach a new high peak. The total is placed at $2,558,719,168, an increase of nearly 13 per cent over the last fiscal year, which itself set a new record.

The spending is spread among twenty-one departments, agencies and commissions concerned in whole or part with health or medicine. They range from an impressive $825,024,300 for the Veterans Administration to a small sum of $12,145 for running the Office of the Attending Physician of Congress.

In between is a broad range of health and medical activities, including money for implementing the many health programs inaugurated by the 84th Congress. The totals are compiled each year by the American Medical Association's Washington Office. The report, the only consolidated Federal medical budget published, is based on actual appropriations by Congress and program data supplied by the federal agencies.

The medical budget total, divided into cost for each man, woman and child in the country, amounts to $15.17 a year, while each family in the United States will be paying $54.61 for this spending, based on Census Bureau figures for population, family size and employment.

Compared with last year's spending, the Defense Department has dropped to second place with its spending estimated at $790,105,000, thus giving way to the VA. The Defense Department shift from the top spending spot, despite a $41 million item for the new dependent's medical care program, is due primarily to more effective joint utilization of facilities, fewer personnel assigned to operation and a planned drop in hospital and dispensary construction.

Department of Health, Education, and Welfare spending for the year ending next July 1, amounts to $772,661.800, which puts that agency's total within striking distance of the two top spenders in the health-medical field. Compared with last year's $526,935,400, HEW spending this year is up a resounding 46 per cent, due in part to more Hill-Burton hospital construction money, record research funds, and permanent and total disability payments.

The accompanying table shows the spending by the twenty-one agencies this year and last.

* * *

NOTES: The long-awaited military dependents' medical care program authorized by the last Congress went into effect December 7. At the height of the program, as many as 800,000 persons not now getting care are expected to be receiving treatment either at military facilities or through private physicians and hospitals. It was launched following a series of negotiations with state medical societies over contracts covering the provision of care outside military hospitals and clinics.

Agency	*Fiscal 1957*	*Fiscal 1956*
Veterans Administration	$ 825,024,300	$ 790,185,800
Department of Defense	790,105,000	818,104,500
Department of Health, Education and Welfare	772,661,800	526,935,400
Federal Civil Defense Admin.	49,810,000	30,450,000
Atomic Energy Commission	31,525,000	27,700,000
International Co-operation Admin.	29,310,000	25,441,000
Department of State	15,496,000	13,669,790
Federal Employes Health Program	10,000,000	6,000,000
National Science Foundation	8,000,000	5,000,000
Department of Labor	7,151,126	7,336,000
Department of Interior	6,138,205	5,770,000
Panama Canal Zone	6,055,300	5,702,900
Department of Treasury	3,511,700	2,990,000
Department of Justice	1,580,000	1,470,000
Federal Trade Commission	1,000,000	1,000,000
Department of Commerce	547,914	277,586
Civil Service Commission	386,000	382,600
National Advisory Committee to Selective Service	180,000	180,000
President's Comm. for Handicapped	134,678	130,000
Health Resources Advisory Comm.	90,000	101,000
Office of Attending Physician of Congress	12,145	——
TOTALS	$2,558,719,168	$2,268,826,576

* * *

Dr. Leroy E. Burney, PHS surgeon general since last August, has announced a number of shifts in major posts within the service. They include Dr. John Cronin, chief of the Hill-Burton program, to head the important Bureau of Medical Services; Dr. Jack Masur, from this bureau to directorship of the Clinical Center at Bethesda, Md.; Dr. G. Halsey Hunt, associate

(Continued on Page 1448)

AMA News Notes

AMA TO HONOR YOUNG SCIENTISTS

The two high school students winning top AMA awards at the National Science Fair next spring will be invited to be guest exhibitors at the AMA's annual meeting June 3-7, 1957, in New York City. Dr. Alphonse McMahon, chairman of the Council on Scientific Assembly, will serve as chairman of the AMA judging committee at the Fair in Los Angeles, May 9-11, 1957. The AMA awards—two "firsts" and two "honorable mentions"—are in addition to those awarded by Fair officials, and are presented by AMA for the best exhibits in the basic medical sciences as an encouragement to scientifically-talented students to enter the study of medicine. This will be the second year of AMA participation.

Approximately 800 persons will attend the National Science Fair, featuring an expected 340 student exhibitors—two finalists from each of the 170 co-operating regional fairs. More than 250,000 high school students now are building exhibits for the 1957 preliminary fairs sponsored by community groups interested in the development of young scientists.

The National Science Fair has increased in size from thirteen supporting regional fairs in 1950 to the 170 fairs expected to send finalists this spring. A conisderable part of this growth is due to stepped-up activity by medical societies in sponsoring or aiding local fairs. The AMA House of Delegates noted this expanding participation and urged even greater support of science fairs by medical societies in a resolution adopted at the 1956 Annual Meeting. Information on organizing and operating a local high school science fair is available from Science Clubs of America, 1719 N Street N.W., Washington, D.C.

NEW AMA TV FILM

A new twenty-eight-minute dramatic film designed to show the "human side" of medicine is the third in a series of television programs produced by the American Medical Association for use by local and state medical societies. Entitled "Even For One," the motion picture will be available for bookings on local television stations after January 1, 1957.

Central character in the film story is Dr. Harry Austen, the beloved general practitioner in a middle-

(Continued on Page 1444)

New concept in patient feeding

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The restoration and maintenance of proper nutrition, fluid, and electrolyte balance is an ever present problem in the care of many medical and surgical patients. Increasing evidence stresses more and more the complexity of the nutritional needs of the human body. From the known nutrients of a generation ago the number of factors known to be necessary for healthy cellular metabolism has greatly increased, and undoubtedly, even more will be discovered in the future.

The BARRON FOOD PUMP permits an adjustable controlled administration of liquified natural foods through a small (2.5mm) caliber plastic intubation tube at a regulated constant rate of delivery while the patient is allowed to sit up, lie down, or turn on either side as desired.

The BARRON FOOD PUMP also provides a means by which gastric juice, bile, pancreatic, and other upper gastro-intestinal fluids containing essential electrolytes, enzymes, etc. can be returned to the body by adding them to the food bottle.

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NEW AMA TV FILM

(Continued from Page 1442)

sized town. A crisis develops, however, when a youngster is treated for typhoid fever while other patients displaying similar symptoms are treated for food poisoning. One indignant mother tries to stir up the entire community when Dr. Austen refuses to hospitalize her boy as a typhoid case. After convincing the mother and others involved that he did the right thing, Dr. Austen underscores the importance of the "art" of medicine by saying: ". . . when you call me to your side, you are buying what it has taken me all my life and training to learn . . . you are buying my skill, my art, perhaps . . . but most of all my judgment . . ."

Medical societies interested in sponsoring this television film locally as a public service project should contact the AMA Film Library.

MEDICAL EDUCATION MEETING

Graduate medical education for general practice will be the topic of discussion at the opening session of the Fifty-third Annual Congress on Medical Education and Licensure to be held February 10-12, 1957, at the Palmer House, Chicago. The three-day meeting will be sponsored by the AMA's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

Also scheduled for Sunday, February 10, will be a business meeting of the Advisory Board and an open meeting of the Federation. Monday sessions will be devoted to a symposium on "Medical Education Tomorrow" and a program highlighting postgraduate medical education and methods of meeting its challenges. The annual Federation banquet will be held Monday evening. The general subject of "Re-evaluation of the Licensing Examination" will be discussed during the final sessions on Tuesday.

AMA JOINTLY SPONSORS NUTRITION MEETING

"Fats in Human Nutrition" with special emphasis on fats, cholesterol and atherosclerosis will be discussed at an American Medical Association symposium to be held March 15, 1957, in New Orleans. The one-day meeting is sponsored by the AMA's Council on Foods and Nutrition with the co-operation of the Orleans Parish Medical Society, the New Orleans Graduate Medical Assembly, the School of Medicine of Louisiana State University and Tulane University School of Medicine.

Tentatively scheduled are the following presentations: (1) dietary fat—its role in nutrition and human requirement; (2) biochemical aspects of fat, cholesterol and lipoprotein metabolism of importance in clinical medicine; (3) pathologic lesions related to disturbances of fat and cholesterol metabolism in man; (4) epidemiologic studies of diet, blood lipids; (5) metabolic studies of the relationships between dietary fat and serum lipid levels; (6) therapeutic implications of nutritional studies relating to serum lipids. A round

(Continued on Page 1446)

AMA JOINTLY SPONSORS NUTRITION MEETING

(Continued from Page 1444)

table discussion on fats, cholesterol and atherosclerosis also will be held. Speakers include Drs. L. Emmet Holt, Jr., Donald S. Fredrickson, W. Stanley Hartroft, George E. Burch, Edward H. Ahrens, Jr., Fredrick J. Stare, and Ancel B. Keys, Ph.D.

Physicians (particularly general practitioners), nutritionists, home economists and others interested in this field are especially urged to attend. Further information may be obtained from the AMA's Council on Foods and Nutrition.

AMA SURVEYS HILL-BURTON PROGRAM

An AMA study of the Hill-Burton Hospital Construction Program is now underway. Conducted by the Council on Medical Service, the survey will cover the first ten years of the program's operation. It is being undertaken to determine to what extent the original objectives are being fulfilled, what effect recent progress in medical and hospital care may have had on these objectives, and what changes, if any, might be suggested to improve the program. Since recent amendments to the Hill-Burton program include provisions for diagnostic and treatment centers, this study should prove of particular interest to medical societies and individual physicians.

State medical associations have been asked through a brief questionnaire to report observations to the Council. Individual physicians, also, may have experiences or suggestions to offer. If so, such information should be sent directly to the Council's Committee on Medical and Related Facilities.

AMA-AUTHORIZED HEALTH ARTICLES

In the fall of 1954 a series of health articles was launched in THIS WEEK magazine—the Sunday newspaper supplement—with the co-operation of the American Medical Association. THIS WEEK recently announced that due to the enthusiastic response of readers, a collection of these health articles has been published as a large-sized, hard-cover book entitled "How to Enjoy Good Health" by Random House, Inc. In making the announcement, the magazine said that it was "proud of its association with the American Medical Association and the confidence in our journalistic integrity which that implies."

First article in the series was written by AMA's secretary-general manager Dr. George F. Lull. Noted authorities such as Dr. Paul Dudley White and Dr. Jonas E. Salk have brought readers up-to-date information on medical subjects ranging from arthritis to viruses. Each article is written by a top specialist in his field and carefully reviewed by the AMA.

Copies of the book may be secured at most book and department stores or by writing to THIS WEEK magazine, P.O. Box 239, Radio City Station, New York 19, N. Y. Price is $3.95.

(Continued on Page 1448)

(Continued from Page 1446)

FILM ON PROBLEMS OF DEAF

An entertaining story depicting the problems and education of a deaf child is portrayed in a 16mm sound film which now may be obtained from the AMA's Film Library. Entitled "Susan's Wonderful Adventure," this twenty-nine-and-one-half-minute color film was produced for the Clarke School for the Deaf in Northampton, Massachusetts, to help create a better understanding between deaf persons and those with normal hearing. The story covers approximately fourteen years in a deaf child's life. It opens with the parent's discovery of Susan's deafness and closes with inspiring scenes at school graduation exercises. There are no professional actors—roles are played by actual deaf children.

NEWSCOPES

Prints of the fifteen-minute *documentary automobile safety motion picture* "On Impact," filmed for the American Medical Association and the Ford Motor Company at the AMA Annual Session in Chicago now are available for showings at medical society meetings or to the general public through the AMA's Film Library. . . . Detailed *bibliographies of source material* on a wide range of research projects in the socio-economic field which were compiled by the Brookings Institution currently are available from the AMA's Council on Medical Service. The eleven sections cover such subjects as cost, financing and economics of insurance (both government and non-government); personnel (physicians, dentists, nurses and miscellaneous); services and related material (selected groups); population, vital statistics and related material; and general background. . . . *A new publication* entitled "Absence from Work Due to Non-Occupational Illness and Injury" has been prepared by the AMA's Committee on Medical Care for Industrial Workers, joint group of the Councils on Medical Service and Industrial Health. Single copies may be obtained free of charge from the Committee; additional copies cost fifty cents.

AMA WASHINGTON LETTER

(Continued from Page 1440)

chief of the bureau, to a new Center for Research on Aging at National Institutes of Health; Dr. Donald W. Patrick from the Clinical Center to PHS hospital at San Francisco; Dr. Vane M. Hoge, from associate chief of the bureau to Hill-Burton.

* * *

With the death of Rep. Percy Priest of Tennessee and the election of a Democratic House, Rep. Oren Harris, Democrat, of Arizona, assumes chairmanship of the important House Interstate and Foreign Commerce Committee. It handles most health legislation in the House. The companion Senate Committee on Labor and Welfare again will be headed by Senator Lister Hill (D., Ala.).

Editorial Opinion

PATIENTS ARE PEOPLE

A working convention of 3,500 members of the Michigan State Medical Society is under way in Detroit, and a study of the program reveals a sturdiness among physicians reassuring to the rest of us.

The burden of messages to be placed before the doctors is that patients are not just ailing bodies, needing treatment of their physical ills.

By such announced discussion subjects as "emotional care," "psychosomatic problems," "psychosomatic aspects," "psychotherapies" and "medical and psychiatric collaboration," the convention leaders are pointing out that patients also are people, needing the "bedside manner" of their doctor as well as his scalpel and a miracle drug or two. The mere nodding visit of the doctor makes the sick feel better.

In effect, it is preservation of the philosophy of the horse-and-buggy doctor who achieved his miracles with 10 grains of aspirin.

Doctors know they must deal with the foibles as well as with the symptoms of their patients. That is the greatest argument against encroachment of production-line medicine. The ultimate in a system of socialized healing, directed by governmental bureaus, would be a neat, departmental division of the human mind and body.

There would be a doctor for the kneecap and a doctor for the ulcers and a doctor for the brain. Unfortunately, the patient who is sick—or only thinks he's sick—is sick all over.

The family doctor knows the whole person of his patient, mind and body. These annual conventions provide him with an academic brush-up on the newer findings that will help him in his work.

—Editorial in *Detroit Times,* September 25, 1956.

DOCTORS' WIVES

The Woman's Auxiliary to the Michigan State Medical Society is holding its convention in Detroit simultaneously with that of the doctor-husband session—and these doctors' wives deserve an accolade all of their own.

They are the opposites of the so-called "office wife." They are home secretaries, receptionists, telehone diplomats and appointment clerks.

When the office day ends, theirs begins.

They must be awakened at predawn hours because of some other woman's baby. They remain home alone during evening office hours when other husbands are with their families. They listen knowingly at the telephone while some chronic ailer details his symptoms, to be relayed to the doctor. They must recognize a truly urgent call.

They dress in new finery for the big party—and then must sit and wait, or go alone, because of an emergency.

They must restore the perspective and the confidence of the physician when he is shaken—when he fears, in self-condemnation, that a little greater skill, a little more knowledge, a little extra time or a little deeper prayer might have saved his patient.

Much has been written, and it should be, about the doctor dedicated to his profession.

His wife's dedication is thrust upon her; she also serves, even when she only sits and waits, and waits, and waits. . . .

—Editorial in *Detroit Times,* September 27, 1956.

SOME DOCTORS SAY

. . . that only indigent patients can be used for clinical material in medical teaching; both undergraduate and graduate, we assume. Much historical basis for such thinking exists, but these are changing times. The theory that a certain amount of personal dignity must be sacrificed by the "teaching" patient has been disproved in many places.

Economic circumstances are changing. Charity patients are becoming fewer. Over half of our population now has hospital or professional insurance; there has been a 75 per cent increase in the past decade; it has been estimated that 85 per cent of the people in this country will be eventually so covered.

The utilization of paying patients in the teaching of residents and fellows is not new; nor is the success of any resident training program dependent on the availability of any particular class of patients. On the staffs of all large hospitals are teachers of outstanding ability and integrity.

Some doctors feel that part of their responsibility to their patients is to protect them from contacts with students or physicians in training lest they find such an experience embarrassing or annoying. This well-intended protection may not be greatly desired by the patient. Often the "teaching" patient has a feeling of participation and realizes that there are advantages to being a subject of study and a teaching example.

There is no reason to believe that paying patients would be unsuitable teaching material. It is likely that often they would be found to be more co-operative, more faithful and more ap-

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What Do You Know About the Army Medical Training Programs?

Draft eligible physicians and medical students should look into the Army Medical Service Officer Procurement Programs. The Army has several Medical Service Officer Programs that are very attractive and should be investigated before any decision concerning military service is made. The following procurement programs should be of interest:

Medical Student Programs

The Early Commissioning Program was instituted as a means to provide for a continued relationship between the Army Medical Service and the various medical schools. This program is designed to start at the Freshman level medical student. By enrollment in a medical school, applicants are educationally qualified for appointment as Second Lieutenants, Medical Service Corps, U. S. Army Reserve. One of the main features of this program is the selection of 150 of the outstanding Reserve Officer Medical Students between their Junior and Senior years for six weeks clinical clerkship at U. S. Army Hospitals.

Army Senior Medical Students Program

Appointments as Second Lieutenants in the Medical Service Corps of the Army Reserve are tendered to selected Senior Medical Students. Upon appointment, the student will be called to active duty and will be stationed at his school until graduation or completion of the academic year. Students will receive full pay and allowances while attending school. Students must agree to participate in the National Intern Matching Program, and upon graduation, accept appointment in the Medical Corps, U. S. Army Reserve.

Students must agree to serve on active duty for four years, including Internship, if matched for Army Internship—or three years if matched for Civilian Internship. Both periods exclude active duty in Medical Service Corps as students. In effect, a draft eligible medical student who would normally be drafted for two years of service, would only give one year of service for the one year of active duty he received as a student.

Applications for this program should be made during the Junior year.

Army Medical Intern Program

The Army Medical Intern Program provides for Internships in Army Teaching Hospitals each year to approximately 150 newly graduated Doctors of Medicine. Upon graduation, selected applicants are commissioned as First Lieutenants in the Medical Corps Reserve, and called to active duty for assignments of one year Rotating Internships in Army Hospitals beginning July 1 of each year. The Intern Training Program at Army Hospitals has been designed to meet all requirements of the Council on Medical Education and Hospitals of The American Medical Association. The Army Intern Program is of one year duration. There is no "Pay Back" time in this program.

Priority III physicians continue to serve two years following completion of Internship. Normally, they are promoted to the rank of Captain at this time.

Army Medical Resident Program

The Army Medical Resident Program is designed to provide training in the various Specialties leading to Board Certification, with training being conducted in Army Hospitals with individuals undergoing this training as a Regular Army Officer. Each Officer undergoing this training is required to repay one year for each year of training received.

Breaking down the terms of Military Service payable for this training, let the service eligible physician consider the fact that he will be required to serve a tour of duty of two years in the Armed Services, after which he will doubtless return to take a residency as a civilian. By availing himself of a three year Military Resident Training Program, he is only required to serve approximately one year over and above that period of time he would normally be required to serve.

Released through the Michigan State Advisory Committee to the Selective Service System by Major Arthur W. Barker, Army Advisor—107th Medical Bn, MNG, Detroit, Michigan.

SOME DOCTORS SAY

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preciative. Unfortunately, and unjustifiably, the "guinea pig" label has been attached to charity patients, often for rather obvious reasons, but it is doubtful if it can be made to stick.

To the medical student, intern or resident the paying patient more nearly represents his future private patient. The treatment of indigent patients only cannot but distort the relationship of the doctor to the patient and to the community. The patient represents a personality; environment, economic status and emotional influences are important in making a diagnosis.

The concept that the full paying patient liquidates his or her entire medical debt is illogical. A patient's debt to medical science can never be completely discharged by the payment of any sum of money. This is a fact of which the public should be made more completely aware. It should be no secret.—O. A. BRINES in *Detroit Medical News,* October 1, 1956.

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Radioiodine in Diagnosis and Treatment of Thyroid Disorders

A Review of Current Medical Practice in the Smaller Community

By Clarence P. Chrest, M.D.
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IN THE past ten or fifteen years I think everyone has read or heard of isotopes and some of their applications in medicine. The glowing promises of the immediate postwar years have by now somewhat simmered down and in the embers, a few well established uses in clinical medicine are apparent as well as the fact that they are extremely valuable in a multitude of research and industrial situations. The most widely used isotope in medicine today is Iodine^{131}, a fact which is dependent on the peculiar specificity of iodine for the thyroid gland.

To understand what an isotope is, if we adopt the concept of species of elements in which there are subvarieties, each having its own peculiar, identifying characteristics, we will avoid the complex physical reasons for their particular classification. Suffice it to say that elements differ in their chemical characteristics as determined by the number or deficits in the orbital electrons. Isotopes of an element have identical chemical characteristics but have slightly different mass, because of the presence of additional neutrons, or particles without electrical charge in the nucleus. These isotopes of an element must be separated or purified by physical methods dependent upon slight differences in mass. Some isotopes are stable, but those of the heavier elements, particularly, exhibit a tendency to readjustment within the nucleus which contains more than the usual number of neutrons. With the casting off of an excess neutron, energy levels within the atom change and radiations are produced, and the isotope is said to decay, a process which occurs at a certain constant rate with half its strength disappearing in microseconds for certain isotopes and up to days or thousands of years for some others.

The particles cast out in the readjustment of the unstable nucleus are three kinds and have their own characteristics. The alpha is a heavy, positively charged particle of very short range and requires no further discussion here. The beta particle of light mass, like an electron, and having a range of only a few millimeters in tissue, is the chief emission of radioiodine and responsible for the radiation effects in treatment. The gamma particle is essentially the same as two million volt x-rays, has the speed of light, and is never completely absorbed in tissue, although reduced. This is the particle we measure with the scintillation counter. It is responsible for only about 10 per cent of the radiation effect on the thyroid, but constitutes almost 100 per cent of the radiation hazard because of their infinite range.

Fermi in 1934 produced the first isotope of iodine, I^{128}, with a half-life of twenty-five minutes.

From the offices of Drs. Hildreth, Volderauer, Pearson, Chrest and Gladstone, 458 West South Street, Kalamazoo, Michigan.

Address given before the Kalamazoo Academy of Medicine, February 22, 1955.

In 1938, Hertz, Roberts and Evans first used it in biologic studies and perceived its use as an investigative tool in thyroid physiology. This isotope lacked gamma emission. More important, its short half-life was an overwhelming drawback and today it is only of historic interest. In 1938, Livingood and Seaborg, using the cyclotron, produced three new isotopes of iodine with longer half-life permitting satisfactory use in biologic research. In 1939, Hamilton and Soley first used I^{131} in human beings, and by 1941, Hertz and Roberts treated the first case of thyrotoxicosis. I^{131} loses half its strength in eight days and is the iodine isotope of choice today. After the hiatus of the war years, I^{131} became available in practically unlimited quantities from the atomic piles of Oak Ridge, and in 1946 was released to the medical profession; thereafter, its use as a diagnostic tool and curative agent spread rapidly. From 1946 to 1951 a large fund of clinical knowledge concerning its use was accumulated by investigators in the larger centers.[1]

From the foregoing, there have been these general consequences:

1. A simple and reliable test of thyroid function.
2. The ability to induce a prompt, nonsurgical, remission of hyperthyroidism.
3. Improved results in the treatment of thyroid cancer.

These advantages are now available to patients in smaller communities as physicians qualified to use isotopes medically have increased. Generally speaking, however, at this time thyroid cancer is a research problem insofar as treatment by radioiodine is concerned, and is probably best managed in large centers where patients with this diagnosis are seen frequently. The following remarks then will deal with use of this material as a biologic tracer in the study of thyroid function, and as a source of local internal radiation in the thyroid gland for the treatment of hyperthyroidism in a medium sized community.

Because of its chemical and metabolic identity with ordinary iodine, here then we have a method of labeling chemical elements so that they can later be detected in living organisms without resorting to dissection or any other destructive sampling method. The avidity of the normal thyroid gland for iodine has long been known, and increased or decreased concentrations in the gland had been related previously to physiologic overactivity and underactivity by chemical methods. With this tool then, *in vivo* measurements of the *total amount or rate of uptake* are possible. The scintillation counter can tell us what percentage of the dose of iodine is present in the gland twenty-four hours following ingestion, ordinarily between 15 and 35 per cent in normal people. Usually determination is also made at four hours and in some cases, where hyperthyroidism is suspected, a more critical evaluation, a determination of the rate of uptake, can be made by serial counts at ten-minute intervals for up to two hours, and the resulting curve compared to the range of normal. In any biologic measurement, some overlapping of normal and abnormal occurs at both ends of the scale. It occurs in this test to a lesser extent than in the basal metabolic rate (BMR) and some of the other laboratory tests commonly available.

Werner presents a comparative study of normal subjects having both the BMR and tracer iodine study, this without the refinement in technique in use today, carried out at Presbyterian Hospital in New York several years ago.[2] Of 113 normal subjects, the tracer study found 17 per cent outside the usually established limits of normal, while by the BMR, 28 per cent were outside the normal limits. When the euthyroid subjects whose radioiodine uptakes were outside normal limits were checked against the BMR results, about half were in the range of normal and half were not. When the individuals whose BMR was outside the limits of normal were checked against the tracer study, only about 20 per cent were abnormal on the tracer study. Excitement or emotion limit the value of the BMR, since the inability to relax and increased muscular tonus accompany nervous tension and are reflected by increased oxygen requirements. Muscular exertion before the test, even heavy exercise a day or so earlier, will alter the oxygen requirements. Consequently, repeat studies are frequently necessary on basal metabolism tests, whereas the need for repetition is rare with the tracer study. Finally, there are many other disorders such as leukemia or the lymphomas, hypertensive disease, or fever in which the BMR may be elevated as part of the disorder, unrelated to an underlying increase in thyroid function. Stimulant drugs may have the same effect.

This is not to say that the BMR does not have its value, but like a patient's temperature it is non-

specific and may have various causes. The iodine uptake is related to one thing, thyroid physiology, and reflects changes in the physiology quite accurately. Its severest limitation is a factor which is actually under the physician's control, that is, alteration of thyroid physiology by specific thyroid medication which is reflected in the iodine tracer study. Therefore, the test should be done before the patient receives Lugol's solution, propylthiouracil or its derivatives or dessicated thyroid or thyroxin. Contrast media used in cholecystogram, the pyelogram, bronchogram or myelogram are rich in iodine and will saturate the body for varying periods of time. Also to be watched are the cough syrups many of which contain iodides as well as other proprietary preparations containing iodine or thiouracil-like substances. Where the patient conceals the fact of medication, the cases of factitious hyperthyroidism caused by taking of dessicated thyroid, the discrepancy between the low uptake of iodine which is in the myxedema range, and the clinical appearance of the pseudohyperthyroid patient with an elevated basal metabolic rate can be the clue to an otherwise obscure diagnosis.

It should not be inferred that a laboratory test is a substitute for clinical judgment. The iodine uptake study is a reliable indicator of thyroid physiology but should be interpreted with other information to make the diagnosis. The BMR may be a good test in the average case, but when there is need for a diagnostic test in the borderline case, the tracer dose of radioiodine is more accurate. In the difficult case, a battery of tests is indicated as results of the iodine uptake, BMR, serum cholesterol and protein-bound iodine are correlated with the clinician's judgment to make a diagnosis. In accuracy and availability, the tracer iodine study is most useful and has the advantage of minimum time and discomfort to the patient.[3] This test is performed with accuracy on decompensated cardiac patients, patients with asthma, those with fever or lung pathology, as well as infants and children.

Tracer "mapping" is possible because of the affinity of functioning thyroid tissue, wherever located, for the radioactive labeled iodine. Substernal goiter may be detected in this manner, and various intrathoracic masses or undiagnosed cervical tumors can be studied for possible thyroid activity. A disappointingly low percentage of metastases from cancer of the thyroid retain functional activity, but if they do localization is possible by this technique.

The inherent characteristic of functioning thyroid tissue to concentrate iodine permits internal irradiation of the gland by means of the beta and gamma radiations of I^{131}. The tracer dose is an extremely small amount, while the treatment dose is 400 to 1000 times in magnitude and, being concentrated in the functioning cells, can deliver sufficient radiation to decrease or abate thyroid function. This property of radiation has been known for years and used successfully in x-ray treatment of hyperthyroidism. The advantage of radioiodine treatment is that the radiations are concentrated on the particular cellular elements we wish to change without affecting skin, blood vessels and adjacent structures. The treatment dose is given orally, usually on an ambulatory outpatient basis and without loss of time from the patient's work. The extremely toxic patient is prepared with propylthiouracil and sedation over a period of weeks, similar to presurgical management, except that iodides are prohibited. Side effects of the treatment are so slight as to generally go without notice, but some patients will mention a tightness of the throat about one week following the dosage. Effects on the patient's hyperthyroidism are apparent in three weeks to two months. If further treatment is required, this is established by evaluation at the end of about three months.

Proper selection of patients for medical thyroidectomy is just as necessary as with any surgical procedure, if good results are to be obtained. Generally speaking, all patients with diffuse toxic goiters with or without exophthalmos are good candidates. Those with nodular goiters are probably best treated surgically, but can be accepted for this treatment if they are a poor surgical risk because of age, cardiac, renal or other complications. Regression of the nodules following usual treatment dosage for thyrotoxicosis is good evidence for their benign nature, since this amount of radiation will leave malignant nodules relatively unaffected. Consequently, the indication for surgery in a questionable case of malignancy is removed and the thyrotoxicosis relieved. Postsurgical recurrences of diffuse or nodular toxic goiter may be treated, and certainly should be, if there has been injury to recurrent laryngeal nerve. The patient who is intolerant of antithyroid drugs is also a candidate. Pregnancy is an absolute contraindication, as the fetal thyroid concentrates iodine after the third

month—a fact which also makes the diagnostic tracer dose unsatisfactory after the second month of pregnancy. Surgery is desirable for young women in the child-bearing years, although some physicians accept these patients for treatment and by now many have had normal children following treatment. Any suspicion of malignancy or of nodularity of the gland in young people is an indication for surgery. Large glands are relatively resistant and best treated surgically. Possibility of carcinogenesis is generally believed to be small, but this question cannot be settled for many years. To date, after fifteen years of radio-iodine therapy, no cases of malignant breakdown traceable to radiation are reported. However, it is advisable to reserve radio-active iodine treatment to those patients over forty years of age. High risk patients, or those refusing surgery, are the exception to this rule.

It would be possible to give a single sufficiently large dose of iodine to induce remission in 100 per cent of patients, but the incidence of hypothyroidism would be prohibitively high. Furthermore, there is a tremendous variation between patients in the radiosensitivity of the thyroid gland. It is preferable to select a smaller dose initially and treat again those patients who do not obtain remission after one dose.

A summary of twenty published reports on over 1700 cases published by 1952[1] indicated satisfactory remission in 80 per cent, a hypothyroid rate of 9 per cent, unsatisfactory result in 5 per cent, and incomplete information on the remainder. More attention to selection of patients and in particular to dosimetry has shown improvement in results since that time. Aiming at a step-like remission, Gordon and Albright[4] reported on 120 patients in whom they have obtained the following results: 49 per cent were euthyroid with a single dose, 79 per cent obtained remission with a second dose, 92 per cent obtained remission with a third dose, and 98 per cent had remission with a fourth dose; 1.6 per cent (two patients) required more than four doses; and posttherapy hypothyroidism occurred in 2.5 per cent of cases. An incidence of hypothyroidism around 15 or 20 per cent more nearly approximates the experience of most clinics.

These are impressive results and show what can be accomplished by deliberate step-wise remission. Other careful workers are duplicating these results.

Blumgart[5] has recently published the results of his treatment of incapacitated euthyroid cardiac patients with radioiodine. Rationale of the treatment is that lowering the total metabolism of the patient so reduces the systemic circulatory requirements as to place them within the limits of the cardiac reserve. Review of 1070 patients from his and other clinics showed that in angina pectoris, the treatment was worthwhile in 75 per cent, with excellent results in 40 per cent and good in 35 per cent. In congestive heart failure, the treatment was worthwhile in 62 per cent, with excellent results in 23 per cent, good in 39 per cent, and considered not worthwhile in about 40 per cent. This procedure is palliative for cardiac cripples and should be regarded as an adjunct to recognized medical measures. It is unwise to treat patients who are in terminal phases of their diseases, particularly since two to six months intervene before the hypometabolic state is attained. A daily dosage of dessicated thyroid is usually administered then to maintain the lowest metabolic rate consistent with comfort.

Similarly, in those unfortunate patients with chronic and disabling pulmonary emphysema, the reduction of the patient's metabolic requirements to a level within reach of the pulmonary reserve by a medical thyroidectomy offers the possibility of rehabilitation. These patients must be carefully selected for this form of treatment following a thorough trial of usual medical measures.[6] Certain cases of severe Parkinsonism are benefited greatly by medical thyroidectomy, as pointed out by Schwab and Chapman[7], but only a small series of this type of case have so far been assembled.

Summary

Test of thyroid function with radioactive iodine is the most accurate method available outside of metropolitan centers and offers advantages in convenience and ability to study patients with pulmonary or cardiac disease or fever. Treatment of thyrotoxicosis with radioiodine is now available to many smaller communities. Medical thyroidectomy is safe and offers the possibility of rehabilitation in selected cardiac patients who have angina or decompensation, and in disabling pulmonary emphysema.

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(Continued on Page 1477)

What is New in the Treatment of Ulcerative Colitis?

By David J. Sandweiss, M.D., and
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DURING recent years a number of significant advances have been made in the management of ulcerative colitis. As a result, the outlook for patients with this disease is much brighter than ever before: many more patients respond to a medical program; of those who are subjected to ileostomy and colectomy, most are rehabilitated and returned to a normal, active and useful life.

Essentially, the new treatments of ulcerative colitis take the form of improvement and refinement of the basic medical program of the past, in the four following ways: (1) We use a highly effective new drug, azulfidine; (2) we use steroid hormones; (3) we use newer methods of nutrition in selected cases; and (4) in the event the patient needs a surgical procedure, he now has the advantage of the advances made in surgery and of the improvements made in ileostomy appliances.

Azulfidine

In our opinion, the most effective drug used in ulcerative colitis during recent years is azulfidine. It is an azo compound of sulfapyridine and salicylic acid, chemically combined (benzol-sulfonyl-(amino-pyridine)-aza-salicylic acid). It was first referred to as salicylazosulfapyridine, then as salazopyrin and later as azopyrine. Now it is called azulfidine. Dr. Nanna Svartz of Sweden introduced this drug in 1948, though she had used it on patients with rheumatoid polyarthritis as early as 1942. Noting favorable effect on the arthritis of these patients, she then employed it for the arthritis associated with ulcerative colitis, with clinical improvement of both arthritis and ulcerative colitis.

In 1948 Svartz[1] reported her results for 124 patients with chronic ulcerative colitis and/or rheumatoid arthritis. Of the patients with colitis, ninety per cent responded promptly to this drug by amelioration or complete disappearance of signs and symptoms. One year later, Bargen[2] reported encouraging results in eight of twelve cases. In 1953, Morrison,[3] in his study on sixty patients over a three-year-period, reported that seventy per cent of his patients either became symptom-free or improved on azulfidine therapy, compared with 37 per cent of similar results in a control series of patients.

Svartz,[4] summarizing her twelve years' experience with azulfidine, during which time she treated 366 patients, reported that 84 per cent of the 366 ulcerative colitis patients improved on therapy with this drug. In 5 per cent of her patients the drug had to be discontinued owing to side effects, principally drug-fever and rash. Five patients developed leukopenia. It should be noted, however, that Morrison[3] found that 21 per cent of his patients revealed an intolerance to the drug: headaches, nausea, dermatitis or secondary anemia.

More recently, Bargen[5] related his experiences with the drug in over 600 cases. He stated: "It is the most valuable drug that has been introduced for the treatment of ulcerative colitis in the years that I have been interested in this problem."

We used azulfidine (as an adjunct drug) in thirty-two patients, particularly in the chronic patients who develop periodic relapses. The drug comes in one-half gram tablets. We usually prescribe two tablets (1 gram) four times daily; at times, two tablets are given every three hours during waking hours, two weeks on and one week off. Twenty-three (71 per cent) of our patients improved considerably while on azulfidine therapy. Some patients did well on prolonged use of the drug, daily, for months and months, using only one tablet four times a day. These patients, however, are not cured of the disease. Rather, improvement or a remission results. Reduction in number of stools and bleeding usually occurs within a few days to a week. Occasionally, a patient may develop nausea and at times headache. One of our patients developed leukopenia which cleared up shortly after the drug was discontinued. Nevertheless, our experience with azulfidine is

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Presented by Dr. Sandweiss before the Tenth Annual Michigan Clinical Institute, Detroit, Michigan, March 9, 1956.

most encouraging. Despite the fact that we have no data on a simultaneously treated control series, (with another drug or with a placebo) we are of the opinion, based on our past experience, that azulfidine is definitely a valuable adjunct to our therapeutic regimen for this disease. At times the addition of azulfidine to the basic medical program produces dramatic results.

It is not definitely known how azulfidine acts to produce clinical improvement. However, Svartz[4] refers to S. Helander, who found through fluorescence microscopic investigations that this compound has an affinity for connective tissue. Svartz reasons that "since the main changes in cases of ulcerative colitis are localized within the submucous connective tissue, it is bound to be advantageous" to treat this affection with such a drug. Whatever the rationale, I have no hesitancy in suggesting that this drug be given a trial in recurrent, moderately severe cases of ulcerative colitis.

ACTH, Cortisone and Meticorten

The first reports on the use of ACTH and cortisone in ulcerative colitis appeared in 1950.[6,7] Since that date, the literature in this country and in England records 506 cases.[8] Seventy-six per cent of the patients were improved during therapy with these hormones.[6-16]

A review of these published reports warrants the following summary:

1. Nearly all authors agree that ACTH and cortisone are capable of inducing a clinical remission in some cases of ulcerative colitis. As stated above, of 506 cases reported in the literature, 76 per cent were improved.[8]

2. These hormones are most effective in the fulminating phase of the disease and also during periods of toxic exacerbations which are associated with such complications as arthritis, erythema nodosum, pyoderma gangrenosum and iritis.

3. In the acute fulminating phase of the disease, when ileostomy is under serious consideration, use of the hormones may initiate a remission and make surgery unnecessary or convert an emergency operation into an elective procedure.[17]

4. Clinical remissions, when they occur, are similar, as a rule, to those seen without steriod therapy; however, they occur sooner than without steriod therapy.[15]

5. These hormones do not cure ulcerative colitis. They are used only as adjuncts and not as substitutes for the basic medical program.

6. Relapses are common and may occur at varying intervals after hormone therapy is discontinued; repeated courses of hormone therapy may induce further remission, though this does not always follow.

7. Kiefer and Elliott,[11] Wirtz, Rehfuss and Yantes,[12] Elliott and Giansiracusa,[16] as well as Kirsner and Palmer,[15] observed a number of patients who have enjoyed uninterrupted remissions while taking small doses of ACTH or cortisone over a period of several months. Whether these hormones have a sustaining effect in the same way that ACTH and cortisone have in many cases of rheumatoid arthritis deserves further study.

8. ACTH and cortisone are "powerful drugs" and *should not be used indiscriminately.* The patients must be observed carefully for complications, the symptoms and signs of which may at times be masked. The following complications and side effects have been reported: (a) Large undermined longitudinal ulcers in the rectum and colon without significant fibrosis;[18,19] (b) recurrence of peptic ulcer or new ulcer formation;[20,21] (c) retention of sodium, loss of potassium and also decrease in intracellular potassium;[22,23] (d) gastrointestinal hemorrhage;[5] (e) perforation of colon with peritonitis;[18,24-26] (f) intercurrent infection as pneumonitis or cellulitis;[26] (g) septicemia;[15] and (h) hypercortinism.[5]

We employed these hormones in nineteen patients with good results in thirteen (68 per cent). Ten of the thirteen patients subsequently developed recurrences. Five of the ten patients were later subjected to elective surgery. These nineteen patients were among the more acutely ill patients in our series of fifty-two.

In the acute toxic phase of the disease, we administer ACTH daily as an intravenous drip, 20 mg. in 1,000 cc. of 5 per cent glucose in water over a six- to eight-hour period. When clinical improvement occurs, the dose of ACTH is gradually reduced and then discontinued, usually within a week or 10 days. In the moderately severe toxic cases we administer ACTH parenterally, 80 mg. daily in divided doses. With clinical improvement, the dose of ACTH is gradually reduced until discontinued. In less severe cases that fail to respond to the usual medical program, we prescribe cortisone orally. Initially, we administer 200 mg. daily, in four divided doses, for

a period of two days. On the third day, the dose is reduced to 100 mg. daily, and three days later to 80 mg. daily in four divided doses. The latter dose is maintained for about a week to ten days, when the dose of cortisone is further reduced gradually until discontinued. We have not used hormones longer than three to four weeks. Our patients have not experienced any of the complications listed above.

The mechanism by which these hormones benefit ulcerative colitis is not known. The beneficial clinical effect may conceivably be due to nonspecific action of the hormones. However, whatever the mechanism, it appears that these hormones have definite value in selected cases of ulcerative colitis. Their administration tends to decrease fever, decrease the number and fluid-content of the stool, improve the patient's sense of well-being and improve the appetite. But they must not be used indiscriminately because serious complications may and do occur occasionally during their administration.

We have had no experience with Meticorten® (prednisone) in ulcerative colitis. Dr. G. Kenneth Hawkins[27] of Schering Corporation advised us that he has in his files reports covering twenty-nine patients treated with varying dosages of this hormone. He stated that "best results seem to occur with high dosages of 60 to 80 mg. or more daily. Of these twenty-nine patients, thirteen had excellent results; eleven had good results; one, a fair result and four poor results."

Kirsner[28] also employed Meticorten® in ulcerative colitis, apparently with encouraging results. "The daily dose varies from 30 to 60 mg. in divided amounts. Occasionally we have given as much as 80 and 100 mg." At these larger dosage levels, hypercortinism and gastrointestinal complications may occur, as with the other steroids.

Nutrition

With progression of this disease a variety of systemic disturbances may occur. While the literature refers to many nutritional, metabolic and other complications, we in our practice have been confronted chiefly with nutritional problems and associated systemic complications, such as arthritis, erythema nodosum, pyoderma gangrenosum, uveitis and, occasionally, iritis. Patients with nutritional deficiencies are usually in a state of protein deficiency and negative nitrogen balance.[29] Because of anorexia, their caloric and protein intake are inadequate. Moreover, they lose considerable protein in the stool in the form of blood, pus and mucus. These patients not only must have between 3,000 to 3,500 calories per day, but also, must have 125 to 150 gms. of protein per day to permit tissue regeneration and repair and to establish a state of positive nitrogen balance. A change to a positive nitrogen balance may herald clinical improvement.[29]

We have found several propietary interval feedings helpful, at times, in increasing the protein and caloric intake:

Predigested Protein (Ledinac).—One tablespoon as a serving, dissolved in milk or fruit juice or water. It adds 2.16 grams of carbohydrates, 2.7 grams of protein and 0.216 grams fat—a total of twenty-one calories per serving. Four servings per day provide an additional eighty-four calories.

Emulsified Fat (Ediol).—One ounce (two tablespoons) as a serving, diluted in milk or fruit juice. This adds 150 calories as predigested fat. Four servings (two tablespoons each) add 600 calories per day.

A preparation of Sustagen, Meritene,*** (Sugar and Water—Sustagen—9½ teaspoons, Meritene—2 teaspoons, sugar—2 teaspoons, chocolate flavoring—1 teaspoon, and water ¾ cup).—This preparation may be served at 10 A.M., 2 P.M., and 6 P.M. Each serving provides approximately 105 grams of carbohydrates, 30 grames of protein, nine grams of fat—a total of 620 calories. Three daily servings supply an additional ninety grams of protein and 1,860 calories.

Fortified Milk Mixture.—A cup of powdered skim milk when added to a quart of milk adds 42 grams of protein, 1 gram of fat and 62 grams of carbohydrates—a total of 425 calories. Three glasses of this milk mixture, i.e., one glass between meals and at bedtime, as three interval feedings, provide 45 grams of protein, 24 grams of fat and 72 grams of carbohydrates—a total of 660 calories. Dextri-Maltose may be added for additional carbohydrates and calories if indicated. This mixture is the least expensive supplementary or interval feeding and is as effective as any of the others mentioned, in those tolerant to milk.

Tube Feeding of Homogenized Foods (Barron Pump).—All too frequently these patients do not

*Sustagen, a powder containing powdered whole milk, non-fat milk solids, calcium caseinate, dextrose and Dextri-Maltose plus vitamins and iron.

**Meritene, a whole protein supplement, fortified with vitamins and minerals.

TABLE I. FORMULA FOR CONTINUOUS HOMOGENOUS TUBE FEEDING
(Barron Pump)

Ingredients	Measures	Grams	P	F	COH	Cal.
Pureed liver	1 cup	250	40.0	9.7	2.5	270
Egg white	9	250	27.0	2.0	—	125
Egg yolks	15	250	40.7	79.7	1.7	902
Skim milk powder	1 cup	250	89.0	2.5	130.0	905
Pureed peas	1 cup	250	1.7	0.5	32.8	127
Liquid skim milk	6¼ cups	1500	52.5	1.5	76.5	540
Dextri Maltose #1	7½ cups	850	—	—	850.0	3400
Emulsified fat (Ediol)	6⅔ tbsp.	100	—	50.0	12.5	500
Total			251.0	146.0	1106.0	6769
1 quart contains:			84	49	369	2256

Note: Mix ingredients skim milk powder, dextri-maltose, egg white, egg yolks, liver, peas, and emulsified fat (Ediol) together, and stir in a bowl or a mixer until a smooth paste is obtained without lumps. Add liquid skim milk and continue beating until mixed thoroughly. Strain through a gauze or fine mesh strainer. Keep in refrigerator.

consume an adequate diet even though served with expert help of a patient dietitian. In these patients we resort to the recently introduced method of tube-feeding described by Dr. James Barron. By this method some of our patients have been fed approximately 1,100 grams of carbohydrates, 250 grams of protein and 150 grams of fat, totalling about 6,800 calories in each twenty-four hours (Table I), with sufficient minerals and vitamins, and have gained fifteen to twenty pounds in weight in two to three weeks. In my opinion this is a major advance in the care of the chronic malnourished debilitated patient whose appetite is at a low ebb and who will not or cannot eat.

At times, however, we are disappointed even by this method of treatment. Several of our patients were fed this highly nutritious diet by means of the Barron pump for periods of two weeks or more, without improvement in their physical status, and with little, if any, gain in weight. These patients are being studied now at Sinai Hospital of Detroit by Dr. Stanley Levy and myself. We are measuring both absorption and excretion of isotope-tagged basic food substances "oleic acid I^{131} and methionine S."[35] Our data at present are too limited to permit definite conclusion; however, it appears that patients with ulcerative colitis have an impairment of absorption of these basic food substances, particularly methionine.

Complications and Indications for Surgery

Because of the chronicity of the disease and the not infrequent occurrences of local and systemic complications and, more especially, because of the encouraging results of recent advances in surgery, there is a trend toward earlier ileostomy and colectomy for patients with chronic ulcerative colitis. Improvement in the design of ileostomy appliances has also stimulated this trend. Recent reports appear to justify the trend. Lahey[30] reported on the postoperative mortality of two series of cases with ulcerative colitis: Of 141 ileostomies performed prior to 1947, the postoperative mortality was 18 per cent, while of 102 ileostomies performed between 1947 and 1951, the postoperative mortality was only 2 per cent. More recently, Cattell and Colock[31] noted that "at present the mortality ranges from 1 to 2 per cent." Ferguson[32] reported a mortality of 3.3 per cent in ninety patients. He stated, "One hundred per cent of our patients on their own admission considered themselves improved; 88 per cent of them indicated that they are in excellent or good health." Bacon and Trimpi[33] performed colectomy with excision of the rectum in forty-five patients with a rehabilitation rate of 91 per cent. These and other reports[34-38] indicate that most patients who undergo ileostomy and colectomy return to a normal active and useful life. As a result, Bacon and Trimpi[33] recommended colectomy for borderline cases, long before patients develop the classic indications for operation. They stated that, "weighted against the low surgical risk and the inconvenience of a permanent ileostomy are the benefits of cure of the disease, removal of a precancerous bowel and prevention of thromboembolic disease and a reversal of degenerative liver, kidney and arthritic changes." Suggestions have been made,[33,39,40] that patients with a history of ulcerative colitis of from five to ten years' duration, who still have the disease, should have an ileostomy and colectomy. In fact, Wheelock and Warren[41] recommended this surgical procedure in patients who have had the disease three years or longer.

We object to this trend because the advances in medical measures (nutritional therapy, control of infection with antibiotics, the use of azulfidine and the steroid hormones) enable many patients with chronic ulcerative colitis to do well on a medical program. Also, recent publications stress the reversibility of the disease[42,43] a phenomenon which we also have observed on several occasions. Because of these considerations, we agree with Zetzel[44] that, "it would be most unfortunate if this wave of surgical enthusiasm resulted in too early operation for too many patients." We recommend ileostomy and colectomy only for those patients who have the following conditions, regardless of

TABLE II. RESULTS OF MEDICAL THERAPY
Fifty-two Patients

Duration of Disease	Very Good	Good	Fair to Poor	Poor: (Surgery Performed)
Less than 1 year	—	—	1 (poor)	1
1 year to less than 3 years	5	2	1 (fair)	2
3 years to less than 5 years	—	1	—	3
5 years to less than 10 years	5	5	—	—
10 years to less than 15 years	6	6	—	—
15 years to less than 20 years	3	2	1 (fair)	1
20 years and over	—	5	1 (fair)	1
Total	19-37%	21-40%	4-8%	8-15%*

*Six of these eight patients are in excellent health. The seventh patient died of a coronary thrombosis two months after ileostomy and colectomy. The eighth patient had a resection of the right colon for carcinoma of the cecum six years ago, and is free from metastasis. (See foot note on page 1466.)

Note: Twenty-six (50 per cent) of the fifty-two patients have had ulcerative colitis longer than ten years; fourteen (twenty-seven per cent) longer than fifteen years; and seven (thirteen per cent) longer than twenty years.

TABLE III. RESULTS OF MEDICAL TREATMENT
Fifty-two Patients

Very good		
Asymptomatic 1 to 2 years—7		
Asymptomatic 2 to 4 years—9		
Asymptomatic 4 to 6 years—2		
Asymptomatic 6 to 7 years—1	19-37%	
Good	21-40%	77%
Fair to poor	4- 8%	8%
Poor—Surgery performed	8-15%	15%
Total	52	100%

TABLE IV. INDICATIONS AND RESULTS OF SURGERY
(Eight Patients in a Series of Fifty-two)

Patient	Duration Prior to Surgery	Indications for Surgery	Type of Surgery	Present Status
S.B.	3 years	Frequent BMs; malnutrition; cramps.	Ileostomy (1955) Sub. Col. (1955)	Excellent (1 year)
B.P.	4 years	Frequent BMs; malnutrition; cramps.	Ileostomy and Sub. Col. (one stage)(1955)	Excellent (1 year)
W.G.	26 years	Frequent BMs; malnutrition; cramps.	Ileostomy (1954)	Excellent (2 years)
L.S.	2 years	Frequent BMs; malnutrition; cramps.	Ileostomy (1952) Sub. Col. (1954) Perineal Resec. (1955)	Excellent (4 years)
M.A.	5 years	Frequent BMs; malnutrition; cramps.	Ileostomy (1949) Sub. Col. (1949)	Excellent (7 years)
M.L	Less than 1 yr.	Deep rectal ulcer; partial rectal stricture; malnutrition.	Colostomy (Trans. colon) 1946	Excellent (10 years)
H.S.	2 years	Toxic episodes; pseudopolyposis; glomerulitis; hypertention.	Subtotal Colectomy (1955)	*
B.Z.	15 years	Adenocarcinoma of cecum.	Sub. Col.; Ileo-Transv. colostomy (May 1950)	Free from metast.; (6 years)

**See foot note on page 1466.
*This patient died of a coronary thrombosis two months after subtotal colectomy.
Sub. Col.—Subtotal Colectomy.

the duration of their illness: (1) Acute fulminating colitis, not responding to adequate medical therapy; (2) perforation; (3) rectal and colonic stricture and obstruction; (4) extensive perirectal infection and fistulae; (5) carcinoma or defect suspected of being carcinoma; (6) profuse hemorrhage or repeated severe hemorrhages; (7) extensive secondary polyposis; or (8) semi-invalidism.[45]

Report of Cases

The usual medical regimen, as is well known, consists of symptomatic and supportive measures. The basic measures are as follows: (1) Physical and mental rest; (2) a low-residue, high-protein, high caloric diet or parenteral feedings when necessary; (3) vitamin supplements; particularly A, B, C and K; (4) drugs to control symptoms, such as sedatives, antispasmodics, opiates; (5) drugs to control infection, such as the sulfonamides and antibiotics; (6) iron preparations or blood transfusions to correct anemia when present; and (7) measures to resolve emotional difficulties, if possible.

These measures, applied in varying degrees for different patients, are still basic. With them, and with the newer techniques and drugs described above, my associate and I have had highly satisfactory results.

During the past ten years we have treated medically, in our private practice, fifty-two patients suffering from chronic ulcerative colitis. We have classified our results as follows (Tables II and III): (1) *Very Good*—those without symptoms now and for one or more years; (2) *Good*—those asymptomatic now but who are still subject to occasional mild recurrences of diarrhea. These patients in general, are in a good state of nutrition, pursue their usual occupations, and are not incapacitated by their disease though some of them may require brief periods of hospitalization; (3) *Fair to Poor*—those with repeated recurrences of symptoms, frequently requiring hospitalization or suffering from malnutrition or complications, and (4) *Poor*—those who required surgery.

The results in nineteen (37 per cent) of our patients are classified as very good; twenty-one (40 per cent) as good; and four (8 per cent) are still under treatment and classified as fair to poor (Tables II and III). In the remaining eight patients (15 per cent), medical treatment alone was inadequate, but surgery yielded excellent results in six of them. A seventh patient made satisfactory progress but died a few months later from a coronary thrombosis; and the eighth patient, who was operated on for cancer of the cecum,

is now six years after operation free from metastasis (Table IV)*

In all, nearly 90 per cent of our fifty-two patients are now either in very good or in good health. We are fortunate, indeed, in not having had either a medical or a surgical mortality in our series of fifty-two patients.

Does Higher Incidence of Cancer of the Colon Warrant Earlier Surgery?

The exact incidence of carcinoma of the colon in patients with ulcerative colitis is not known. However, it is generally accepted that the incidence is higher than in the general population of the same age and that it increases with the duration of the disease. The pathogenesis of the neoplasms is believed to be chronic inflammation and irritation, resulting in hyperplasia, proliferation and finally carcinoma.[46]

A review of the literature to 1944 by Lynn[47] indicated a 1.9 per cent incidence of carcinoma in 1467 case (Range: 0-6.3 per cent). A review of the major reports in the literature from 1944 through 1951 by Machella[9] reported an incidence of 3 per cent among 6,890 cases (Range: 0-7 per cent).

Bargan and his associates[48] recently reported on a follow-up study of 1564 patients with chronic ulcerative colitis who had been examined at the Mayo Clinic from January 1, 1918, through December 31, 1937 (fifteen to thirty-five years ago). Ninety-eight (6.2 per cent) of the 1564 patients "subsequently had malignant lesions of the rectum or colon and died." His data indicate that "on the average the death rate from cancer of the rectum or colon among persons with ulcerative colitis is, say thirty times as frequent as that in the general population of the same age and sex." He added, "The patient with ulcerative colitis, however, should not be unduly alarmed for the annual death rate from cancer of the colon or rectum among persons with ulcerative colitis is estimated to be between one and two per hundred."

Of significance is a report on two different series of cases by Kiefer et al.[49] Of 458 patients studied by roentgenography and sigmoidoscopy, the incidence of carcinoma of the colon was 1.9 per cent. In the second series of 226 patients who either came to surgery (214 cases) or came to autopsy (twelve cases), the incidence of carcinoma was 4.4 per cent.

In surgically treated cases and in patients with long-standing ulcerative colitis, the incidence of carcinoma, as reported in the literature, appears alarmingly high. While Lyons and Garlock[35] reported an incidence of 3.9 per cent in 226 surgically treated cases, Bacon and Trimpi[33] and Counsell and Dukes[36] each reported an 11.1 per cent incidence in forty-five and sixty-three surgically treated cases, respectively. Wheelock and Warren[41] reported an 8.8 per cent incidence of carcinoma of the colon in 319 patients. They studied patients who lived ten or more years after the onset of ulcerative colitis and who did not have colectomy before ten years had elapsed.

Dennis and Karlson[37] reported a 20 per cent incidence among those with colitis for over twenty years. Lahey[34] indicated a malignancy rate of "about 30 per cent" in patients who had had the disease with their colon intact ten years.

Lyons and Garlock[35] and Counsell and Dukes[36] reported the highest incidence of carcinoma. In twenty-five cases of ulcerative colitis lasting over twelve years, the incidence of cancer was 36 per cent.[35] In sixteen cases of ulcerative colitis involving the rectum and lasting over twelve years, the incidence was 43 per cent.[35] Among eleven surgically treated cases with a history of ulcerative colitis for more than ten years, there were five cases of carcinoma—an incidence of 45.5 per cent.[36]

In general, these published reports definitely indicate that there is a greater tendency for the occurrence of carcinoma of the colon in patients with ulcerative colitis and that the incidence increases with the duration of the disease. However, we question whether the alarmingly high incidence of cancer indicated above represents the true incidence of carcinoma among patients with ulcerative colitis, even among those having the disease longer than five to ten years. Is it not possible that the nationally known medical institutions attract the more seriously ill patients, most of whom had failed to respond to medical management, and who represent the very group in whom the incidence of colon cancer is high? In this connection, it is important also to recall the

*While this paper was awaiting publication, this patient developed another primary malignant lesion in the sigmoid. This lesion was resected June 19, 1956, and an end-to-end anastomosis was done. There was no evidence of metastatic intra-abdominally from either the first or the second primary lesion. Microscopic examination revealed an adenocarcinoma with invasion of the muscle coats, without involvement of lymph nodes. The patient has been well to date (Nov. 30, 1956).

reports of Felsen and Wolarsky[51] and Lagercrantz[52] who failed to find a single case of carcinoma among 855 and 134 cases, respectively, of ulcerative colitis; Felsen and Wolarsky's series included 134 patients with pseudopolyposis. Over a ten-year period, out of fifty-three cases studied, Ransom[53] found two (3.8 per cent) patients who developed cancer of the colon or rectum. In our series of fifty-two cases, seen over a ten year period, there was only one case with carcinoma of the colon (2 per cent). It should be noted that twenty-six (50 per cent) of our patients have had the disease longer than ten years, fourteen (27 per cent) longer than fifteen years, and seven (13 per cent) from twenty to thirty-five years. The patient who developed cancer of the cecum had chronic ulcerative colitis fourteen years at the time surgery was performed.

Our experience with the incidence of cancer in this disease leads us to believe that the true incidence is nearer the 2 to 4 per cent figure mentioned by Lynn,[47] Machella[9] and Ransom.[53] This incidence does not warrant routine removal of the colon in all longstanding cases of ulcerative colitis. Because the operation of ileostomy and total colectomy themselves entail a mortality, a morbidity, and the difficulties of leading of an ileostomy-life, great caution continues to be warranted in recommending surgery in any but reasonably clear cases. Even if cancer of the colon develops, the prognosis is not hopeless. Reports have recently appeared on a number of patients with five-year postoperative survivals.[17,46,54] The patient with cancer of the colon in our series is alive and free from metastasis six years following resection.*

Summary

Without minimizing the seriousness of the local and systemic complications that sometimes occur among patients with chronic ulcerative colitis, and without minimizing the difficult therapeutic problems that exist when these complications occur, it can be generally stated that as a result of the noteworthy progress that has been made in both the medical and surgical approach to this disease, the outlook for patients with ulcerative colitis is better today than ever before. About 80 per cent of the patients respond satisfactorily to a medical regimen. Of the patients who are subjected to ileostomy and colectomy, most are rehabilitated and returned to normal, active, useful lives.

The following advances have highlighted the progress made in recent years in the medical care of these patients: newer and better means of supplying a nutritious diet; newer drugs, such as the sulfonamides, the antibiotics, azulfidine and the steroid hormones; and newer and better means of controlling fluid and electrolyte losses when these exist. These advances are largely responsible for the increase in the incidence of remissions, the decrease in the incidence of emergency ileostomies and, in the better preparation of the patient for the ordeal of surgery when surgical intervention is indicated.

The achievements in the surgical and postoperative care of these patients are no less noteworthy: ileostomy and colectomy are now being performed in one stage with a low mortality rate; the complications that were associated with the ileostomy stoma have been appreciably lessened; and ileostomy appliances have been improved considerably. As a result, both patient and physician look upon surgical intervention with much greater assurance than before when indications for surgery occur.

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*See footnote on page 1466.

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MILLIONS SPENT ON RESEARCH BY NON-GOVERNMENTAL LABORATORIES

National Science Foundation reports that in 1953, latest year for which such figures are available, a total of about $85 million was spent on scientific research in nonprofit and commercial laboratories. Commercial organizations spent close to $35 million, and nonprofit organizations more than $50 million.

The figures are contained in a NSF publication, Research and Development by Nonprofit Research Institutes and Commercial Laboratories. The report was prepared for the foundation by Maxwell Research Center of Syracuse University. It is part of an extensive survey of research and development in all known United States nonprofit institutions and a sampling of the work in commercial laboratories.

The rapid increase in research—most of the units studied were founded since 1941—is attributed by NSF largely to the expansion of the federal research grants program and to federal aid to private research groups. In 1953, the United States grants made up about one-half of the total spent in commercial research laboratories, and two-thirds of the money spent by nonprofit groups.

Chlorpromazine in the Treatment of Mild Behavior Disturbances

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THE INCREASING concern of parents regarding the emotional well-being of their children has confronted the physician with an enlarging segment of practice devoted to behavior disturbances of varied severity. Child psychiatrists, mental hygiene clinics, mental institutions, and special schools have assumed, by and large, the responsibility for the diagnosis, care, and treatment of the severe behavior disorders or major mental ailments of children. The much more prevalent milder behavior deviations occurring in infancy and childhood present a challenging array of problems to the general practitioner or pediatrician.

A high proportion of the emotional upsets in younger children (evidenced by such symptoms as temper tantrums, sleeplessness, and anorexia) may be reactions to stresses accompanying normal physical development. As the child grows older he may exhibit behavior deviations which reflect feelings of anxiety and insecurity resulting from tensions in his family or social environment. These reactions may also occur in children who do not have sufficient outlets to release the often turbulent emotions which accompany normal growth and development. Typical of these behavior disturbances are aggressiveness, undue shyness, and hyperactivity. Physical symptoms such as urinary disturbances and tics are also frequently encountered.

The child's anxiety and tension are often doubly reflected in his parents whose concern may be much greater than the seriousness of the problem would warrant. It behooves the physician to provide these distraught people with at least temporary help. Psychotherapy for parents and child, although desirable, is time consuming and usually not feasible. Published studies[1,2] have demonstrated the effectiveness of chlorpromazine* in the treatment of severe behavior disturbances; none, however (at least to our knowledge) has reported on the use of the drug in treating comparatively mild disturbances. Accordingly, the following study was conducted to evaluate the drug's efficacy in treating these conditions.

Method

The study was conducted on twenty-two children selected from private practice. Each was chosen for treatment only after his parents had appealed for aid in coping with the child's symptoms. Chlorpromazine was not given to children whose behavior difficulties were only casually referred to, nor to those whose parents seemed to accept such behavior as part of the vicissitudes of child rearing.

Chlorpromazine was given three or four times a day in a syrup containing 10 mg. of the drug per teaspoonful, or in 25 mg. or 50 mg. tablets. The total daily dose was 1 mg. per pound of the child's weight; only occasionally was it necessary to increase the dose to obtain the desired clinical effect. The treatment was never given for more than two weeks, irrespective of the results obtained.

Results

Response to medication was determined by observations of the child and interviews with him and with his parents. Results were classified as "good" if the child experienced a complete or almost complete alleviation of symptoms; as "poor" if symptoms were only partially relieved or not relieved at all. Because of the essentially subjective nature of determining response, no attempt was made to use more exactly defined criteria to classify results.

Of the twenty-two children treated, fourteen experienced a good result; eight a poor result. In the latter group were several children who were treated for some specific difficulty (e.g. poor school adjustment, erratic sleeping habits, excessive fears) but who were not subjected to intrafamily tensions, and whose adjustments were otherwise within normal limits.

One patient experienced a drowsiness which

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*Thorazine, Smith, Kline & French Laboratories, Philadelphia, Pa.

disappeared after the dose was decreased. No other undesirable side effects were noted.

Case Histories

The following brief case histories illustrate the good results obtained.

Case 1.—M.P. was a four-and-one-half-year-old boy who was a very tense, unhappy child with aggressive behavior toward his parents and sister. He showed improvement after being on 30 to 40 mg. Thorazine daily, and became quieter and more manageable.

Case 2.—G.B., a three-year-old boy was a very hyperactive child, restless, tense, with poor appetite and an inability to gain weight. After a few weeks on 25 mg. of Thorazine daily, he gained one and one-half to two pounds, became much less nervous and irritable, and more easily managed. He began to resume his daily nap, and slept better in general.

Case 3.—S.C., who was a nine-and-one-half-year-old girl, suffered from cerebral palsy with petit and grand mal convulsive attacks which were incompletely controlled with anti-convulsive drugs. After starting Thorazine, her mother noticed a definite improvement in the child's general behavior. Although her attacks persisted, she became much easier to manage.

Case 4.—G.R., a girl, aged nine, revealed poor school adjustment, and also had difficulty in falling asleep. There had been no gain in weight or height for from six months to a year, even after the use of adequate doses of thyroid. After Thorazine was administered her mother reported a "different child." There was marked dramatic improvement in her school behavior, eating, sleeping, and general deportment. She gained three pounds in one and one-half months.

Case 5.—L.G., a girl, aged two-and-one-half-years, was overactive and had poor sleeping habits. On 30 mg. of Thorazine daily, much improvement was noted by her mother. The child was more easily managed, slept better, and appeared much more relaxed.

Case 6.—E.M., a three-and-one-half-year-old girl, was a very nervous, irritable child who slept and ate poorly, and was quarrelsome and disobedient. When she was given 3 teaspoons of Thorazine Syrup daily her mother noticed "amazing results." The child gained weight as her appetite improved, and she became more obedient and more easily managed. When she awakened in the morning, a smile replaced her usual grouchiness. Throughout the day she appeared happier and more sociable.

Case 7.—L.S., aged nine years, was a nervous, tense boy with stuttering of moderate severity. After the first few days of therapy he showed great improvement in his speech. He was then taken to an Eastern city by his parents to attend a wedding, after which he relapsed to his former state of nervousness and speech disturbance.

Case 8.—F.C., a three-year-old girl, had been hospitalized for genitourinary workup because of nocturia and the frequent and urgent necessity to urinate during the day. After one week on 40 mg. of Thorazine daily no definite change was noted. However, when the dosage was increased to 60 mg. daily the mother reported a marked improvement. The urinary symptoms including the nocturia completely disappeared. Her temperament became more even, and she was more easily managed and less nervous.

Case 9.—E.B., aged seven years, was a very nervous, irritable boy, with poor sleeping habits. He was argumentative, rude, and displayed aggressive behavior. He was put on 60 mg. of Thorazine daily, after which his mother noticed definite improvement in behavior. He began to awaken in a happier frame of mind, and showed much less irritability. His sleeping pattern became normal. He became more easily managed and was no longer argumentative or aggressive.

Case 10.—F.R., a four-and-one-half-year-old girl had symptoms of nervousness, extreme frequency and urgency of urination. Her general deportment improved and her urinary symptoms completely disappeared after a course of treatment with Thorazine.

Case 11.—D.A., aged four-and-one-half-years, had very poor sleeping habits; she would awaken hourly during the night. She was a very tense, nervous child. After Thorazine was administered, her sleep became entirely normal. Her disposition and deportment also showed remarkable improvement.

Case 12.—B.P., aged nine, was a malnourished colored girl whose chief complaint was persistent head nodding for two months. 60 mg. of Thorazine was prescribed daily, and her symptom disappeared.

Case 13.—H.D. was a two-year-old colored boy who was very tense and irritable, cried excessively and banged his head day and night. Very shortly after starting Thorazine his mother noted a rather dramatic improvement. The head banging completely disappeared, his disposition brightened, and he appeared much happier. The mother commented upon the "tremendous relief" she secured. The family's sleep was no longer interrupted.

Case 14.—P.K., aged eight, was a high-strung, emotional, hyperactive boy. He became much more relaxed and less active after Thorazine was administered.

Discussion

It is true, of course, that many mild behavior deviations are self-limiting and often represent temporary disturbances. Is it desirable, then (in view of chlorpromazine's possible side effects) to treat them with this potent drug? The answer would seem to be "yes" if, as it so often happens, the child's behavior and unhappiness impose an insufferable burden on the parents. Chlorproma-

zine should not be used promiscuously to treat benign or trivial problems.

That the drug is effective in treating mild behavior problems is evidenced not only by the number but by the kind of results obtained. In several patients the response was quite dramatic. It should be stressed that chlorpromazine is not a definitive therapy for behavior problems. It should be considered as a symptomatic or stop-gap approach to an often complex problem.

If no beneficial results are ascertainable within a few days, chlorpromazine should be discontinued. At best, the therapy should not be extended beyond two weeks. With these precautions, deleterious effects from the use of the drug would seem to be negligible. It was our impression that even such short-term use of this medication effected a more than temporary improvement in the child's behavior, attitudes, and disposition. Even the temporary "breathing spell" provides significant relief for the parents' emotional tensions; and helps them to reorient and realign their approach toward their children's behavioral and emotional needs.

Summary

The use of chlorpromazine (Thorazine) as tranquilizing medication in children with behavior disturbances of minor severity is presented. Beneficial results were noted in fourteen of the twenty-two children treated. The improvement in these children helped them and their parents to attain a greater degree of harmony and emotional stability in their relationship. In selected cases, the drug is effective in moderate dosage when given for short periods of time. Dramatic improvement is often apparent. Under these conditions no adverse reactions were observed.

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RETROLENTAL FIBROPLASIA

Retrolental fibroplasia was first recognized as a disease of premature infants in 1942 and is now the major cause of blindness among children. Oxygen administration to premature infants was implicated as a possible cause in 1952. Premature infants should be given additional oxygen only in emergencies and then for as brief periods of time as possible. Three Detroit researchers based this recommendation on a recent study which showed that length of exposure to oxygen is the important factor in producing retrolental fibroplasia, a serious eye disease which may result in blindness. This differs from earlier studies indicating that the concentration of oxygen was the causative factor.

However, because the disease appeared to occur haphazardly and because no information was available on death rates due to curtailing oxygen for premature infants, doctors have been reluctant to change their routine of oxygen administration.

The report in the October *Archives of Ophthalmology*, published by the American Medical Association, is based on a co-operative study made in eighteen hospitals between July 1, 1953, and June 30, 1954, in an attempt to clear up questions about oxygen's effect on RLF and mortality rates.

Of the 786 premature infants born in or brought to the eighteen hospitals during the year, 586 were followed for at least two and a half months. Fifty-three infants were given oxygen for twenty-eight days, the standard procedure at the time. The other 533 infants were given oxygen only when breathing difficulty occurred.

The study showed that on a percentage basis, twice as many infants in the routine-oxygen group developed the early active stages of the disease as did infants in the curtailed-oxygen group. The rate of progression to the later scarring (cicatricial) stages which produce permanent damage to the eyes was three and a half times greater in the routine-oxygen group than in the curtailed-oxygen group.

The rate for both active and cicatricial stages increased as the duration of exposure to oxygen increased, but was not affected by the concentration. Rate of withdrawal from oxygen did not appear to play a role, they said.

The incidence was much greater in infants of multiple birth (twins or triplets) than of single birth. The authors said the reason for this is unknown, but it may be related to the degree of oxygen saturation in the blood. A multiple-birth infant might have less oxygen in his blood before birth than a single-birth baby. When he is given additional oxygen, a relatively greater difference in blood-oxygen saturation before and after birth could result, which might be "a greater insult" to the blood vessels of the eye.

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Three-year Study of Gall-bladder Surgery at Detroit Receiving Hospital

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THE SUBJECT of gall-bladder and common duct surgery will always be an interesting one for many reasons. Some of these cases are anatomical and others involve the nature of the disease and how to approach it. As yet, the exact cause of the inflammatory process and the deposition of gallstones is not precisely known. The diagnosis is occasionally in error, as exemplified by a preoperative diagnosis of cholecystitis and a right upper quadrant incision being followed by an operative finding of no pathologic lesions of the gall bladder. Likewise, cholecystectomy is not always followed by relief of the symptoms for which the patient was operated upon. Noteworthy in any sizable group of cases is an occasional failure to include gall-bladder disease in the differential diagnosis of some other condition. The indications for which individual surgeons recommend cholecystectomy are more or less uniform, with a possible difference in opinion as to the timing of surgical intervention in the face of an acute attack of the inflammatory process. Finally, the discovery of an obstructing stone after common bile duct exploration varies somewhat with each individual surgeon's indications for such exploration.

With these thoughts in mind, we set out to review the operations performed on the gall bladder and common bile duct at Detroit Receiving Hospital in the years 1951, 1952 and 1953. The items examined in each record included the history, physical findings, laboratory studies, roentgenographic studies, operative findings, pathologic diagnosis, postoperative complications, morbidity and mortality. In 1951, there were eighty-six cholecystectomies, and in twenty-three of these cases the common duct was explored. In 1952, sixty-eight cholecystemtomies were performed, of which twenty-one were combined with common duct exploration. In 1953, there were eighty-six cholecystectomies, of which thirty were accompanied by choledochostomy. The ratio between the two procedures is nearly the same each year, in that the common duct was explored in a little less than one-third of all cases in which the gall bladder is removed. A collective review[7] of 25,807 operations for chronic cholecystitis yielded a 23 per cent incidence of common duct exploration.

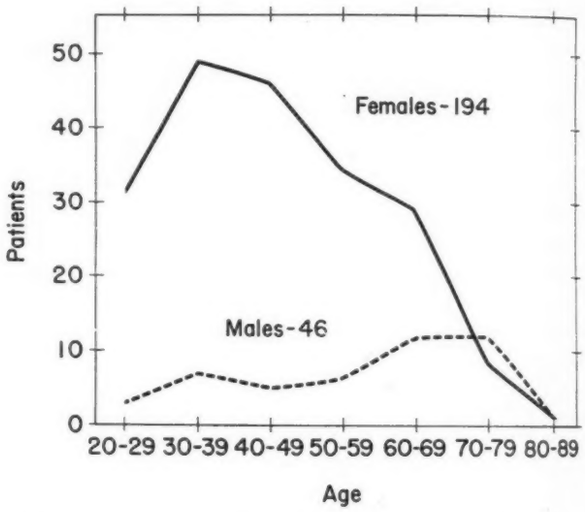

Fig. 1. Number of cholecystectomy operations performed on 240 patients according to the age of the patient.

Age and Sex

If the patients are separated into age groups according to sex, the ratio of female to male in the third to the sixth decade is roughly ten to one. The peak age incidence in the female occurs in the fourth decade (Fig. 1). However, in the seventh and eighth decades, the relative incidence of gall-bladder operations in the male increases not only in respect to the female of similar age but also in respect to the younger male. Insofar as a relatively small number of gall-bladder operations may indicate the overall incidence of cholecystitis, this would tend to support the suggestion made by Robertson[6] that as the advanced decades are approached, the incidence of gall-bladder disease in the two sexes tends to become equal.

From the Departments of Surgery, Wayne University College of Medicine and the Detroit Receiving Hospital.

Symptoms

Attention is now directed to the symptoms as recorded in the histories (Fig. 2). In general, all the patients had either right upper quadrant

240 Cholecystectomies

100 %	right subcostal or epigastric pain
60 %	right subscapular pain radiation
85 %	nausea - vomiting
65 %	fatty food intolerance
80 %	right subcostal tenderness
20 %	muscle spasm

Fig. 2. Incidence of symptoms and signs in patients with cholecystitis and/or cholelithiasis.

pain or epigastric pain, and it was not possible to differentiate the pain localization in respect to any other variable in the clinical picture, such as an increase in epigastric pain with jaundice or in those patients who required common bile duct exploration. Radiation of the pain to the right subscapular region posteriorly occurred in nearly two out of three patients with a fair degree of regularity. Radiation of pain to the lumbar region was only rarely recorded. Nausea with or without vomiting was a consistent symptom and occurred in 85 per cent of the operated cases. There was no demonstrable increased incidence of involuntary vomiting in those patients with common duct distention as has been described.[8] The only other regularly occurring symptom was a history of fatty food intolerance, which occurred in two out of three patients regardless of the type of operative procedure performed.

A history of jaundice could be elicited (Fig. 3) in 30 per cent of the group undergoing duct exploration, while less than 10 per cent of the group undergoing cholecystectomy alone presented this finding. A decrease in stool pigmentation with darkening of the urine was present in 30 per cent of the former group and 20 per cent of the latter. Chills and fever occurred in 10 per cent of both groups of patients. The significant occurrence of these symptoms in the patients who presented no indication for common duct exploration has been used to indicate that there is in some cases extension of the inflammatory process from the gall bladder to involve the liver directly or the associated hepatic bile ducts.[2,4,5]

Physical Findings

The physical findings were those usually described in cholecystitis. In most cases the findings of at least four observers are present on the

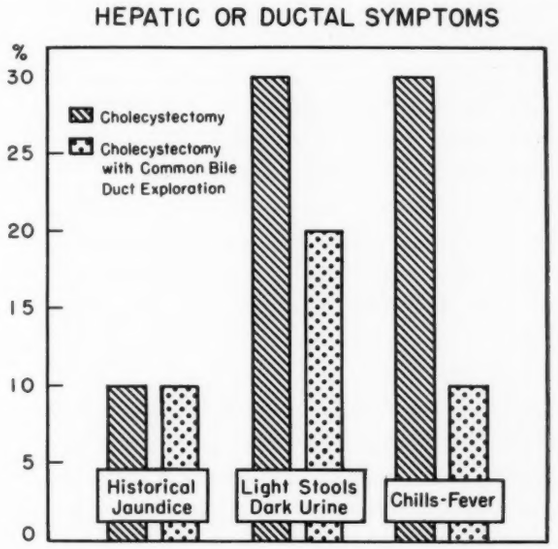

Fig. 3. Comparison of specific symptoms in patients receiving cholecystectomy (a) with and (b) without common bile duct exploration.

charts, and if any one of these observers noted a positive finding in the signs it was tabulated as being present. With the exception of those patients admitted for interval cholecystectomy, all of the remaining patients had some elevation of temperature on admission to the hospital. For the most part, this consisted of low-grade fever, but temperatures up to 103 degrees were recorded in a few patients admitted with early empyema of the gall bladder. Eighty per cent of the patients had subcostal tenderness (Fig. 2) at the time of admission. Twenty per cent had muscle spasm in the right upper quadrant and this spasm was fairly consistently associated with leukocytosis, prolonged operating time and a microscopic tissue diagnosis of acute inflammatory disease in the gall bladder. A palpable mass in the right upper quadrant occurred in almost one-third of the patients. The presence of this palpable mass was not limited to those patients with acute severe gall-bladder disease, and in many cases it was thought to be a palpable liver. Therefore, no correlation of a palpable globular mass to the clinical picture could be determined.

Laboratory Findings

In reviewing the laboratory work, the admitting white blood count was above 15,000 in thirty-

five cases, roughly paralleling the presence of subcostal muscle spasm. The serum bilirubin was determined in most patients and the immediate value was at the upper limits of normal with the exception of the few patients with clinical obstructive jaundice. The cephalin flocculation test was done in approximately one-half of the cases and ranged from a trace to 4 plus in 10 per cent. However, there was an equal percentage of elevated values in those patients undergoing cholecystectomy alone and those requiring duct exploration in addition to removal of the gall bladder. The alkaline phosphatase was determined in 25 per cent of the patients and was significantly higher (6 to 8 Bodansky units) in those requiring common duct exploration. The serum amylase determination was done in 50 per cent of the cases and was elevated in only six patients, all of whom had pancreatitis diagnosed at the time of operation. A prothrombin time and a serum protein and albumin to globulin ratio study failed to reveal anything significant relative to the gall-bladder disease. These tests of liver function were useful only in the general preoperative evaluation of the patient, as were the urinalysis and electrocardiogram.

Roentgenographic Studies

The Graham-Cole test or cholecystogram was done in 189 of the 240 patients and the results of the study were as follows; ninety patients had nonvisualization of the gall bladder but no definite stones were seen; ninety-four had decreased gall-bladder function and a definite diagnosis of cholelithiasis. Only two patients had radiopaque stones discovered on a routine flat plate of the abdomen. Therefore, the majority of gall-bladder calculi were nonopaque and were visualized in 50 per cent of the studies only because of the ability of the gall gladder to concentrate the dye sufficiently to outline the stones. Five patients had the cholecystogram reported as normal. In reviewing these cases, one of the reports was discovered to be in error and stones in the gall bladder could be seen when the roentgenogram was re-evaluated by the radiologist. Two of the cases rechecked were equivocal. Two studies were completely normal. In these five patients, two points of interest were noted. The first, the reason for operation even in the face of reported normal cholecystographic studies; and the second, the findings at the time of operation. Four of the patients were operated upon because of persistent symptoms and the other because of jaundice. All five of the cases with reported normal cholecystograms had pathology in the gall bladder. Four had cholelithiasis and cholecystitis and one patient had a thickened gall bladder, hepatitis, and periduodenitis.

Operation Without Roentgenogram

The fifty-one patients who were operated upon without having a cholecystogram were examined to determine for what reason the roentgenographic study was omitted. Twenty patients were operated upon shortly after hospital admission because of a diagnosis of gall-bladder empyema and impending perforation. An acutely inflamed gall bladder was removed in each case. In twelve patients, no cholecystogram was performed preoperatively because these patients had fluctuating extrahepatic jaundice presumably due to stones. There was a miscellaneous group of patients, twelve in all, who had the cholecystogram omitted for reasons such as palpation of stones at some previous operation, seven cases; a previous cholecystostomy with removal of stones, two cases; a traumatic perforation of the gall bladder, one case; a cholecystoduodenal fistula demonstrated on a gastrointestinal roentgenogram, one case; and finally one case was operated upon after a remission of a typical gall bladder attack on the basis of history and physical findings alone. Of special interest were seven patients who were misdiagnosed preoperatively. Five of these had a preoperative diagnosis of perforated peptic ulcer, for which an Amendola incision[1] was made only to be followed by a lateral extension of the incision because of an early acutely inflamed gall bladder. Two patients had right lower quadrant incisions with a preoperative diagnosis of acute appendicitis, followed by right upper quadrant incisions, when the diagnosis of acute cholecystitis was made on exploration.

Incidence of Gallstones

The incidence of gallstones in the entire group of 240 cases was determined by checking the operative reports and the pathology reports. From these, it was found that stones occurred in all but twelve patients, an incidence of 94 per cent. One of these twelve patients had a normal gall bladder, a cholecystectomy being done because of symptoms and a failure to demonstrate any other

pathologic condition. One case presented a microscopic diagnosis of severe acute cholecystitis, which was noted at operation and for which reason the gall bladder was cultured. The culture was negative. One case presented a chronic cholecystitis with a content described as sludge, and eight other cases were all diagnosed as chronic cholecystitis, each associated with some other pathologic state, such as pancreatic disease or hepatitis. The cholecystectomy done for traumatic perforation of the gall bladder was the other instance of a stoneless organ being removed. Although no long-term follow-up was done in this study, it is to be mentioned at this point that cholecystectomy performed in the absence of stones in the gall bladder has not infrequently been followed by unsatisfactory results in the relief of the patient's preoperative symptoms.[3]

Severity of Inflammation

An attempt was made to evaluate the condition of the gall bladder at the time of its removal according to the severity of the existing inflammatory process. However, this was extremely difficult since the microscopic diagnoses were noncontributory in this respect and analysis of the physical findings and laboratory studies proved to be inconsistent compared to the duration of the symptoms. As previously mentioned, twenty patients were operated upon immediately on admission because of the severity of their disease, signs of toxicity, high fever, and leukocytosis of 17,000 or more. The remaining 220 cases were divided according to the number of days between the remission of the attack of cholecystitis as determined by the patient's symptoms and the day of surgery. Seventy-nine cases were done as interval cholecystectomies, there being a period of at least three weeks prior to surgery during which the patient had no symptoms. Ninety-six cases were operated upon in what was presumably a subacute stage, in that from eight to twenty-days had elapsed since the remission of symptoms and operation. Sixty-five of the cases were done in the seven days immediately following an acute attack. The final group of so-called acute cases are in the group in which a delay in surgery is occasionally recommended. However, if morbidity is evaluated by the number of days of hospitalization required after surgery, those patients operated upon during the acute phase of their disease did not remain in the hospital any longer than those in the subacute or interval groups. The average length of postoperative hospital care required by all three categories was from eight to nine days. Likewise, if morbidity is evaluated by postoperative evaluation of temperature to any significant degree, in this case above 100 degrees, there is little difference between the three groups. The average length of elevation of temperature for the acute cases was slightly more than two days, while in the other two groups it was slightly less than two days.

Indications for 74 Common Duct Explorations

49	historical jaundice with duct dilation 26 of these had duct stones
14	duct dilation alone 2 of these had duct stones
11	miscellaneous One of these had duct stones

Fig. 4. Indications for and results of exploration of the common bile duct at the time of cholecystectomy.

Common Duct Exploration

An evaluation was made of the indications for common duct exploration (Fig. 4). In 65 per cent of these patients, duct exploration was carried out because the patient had historical jaundice. At the time of operation these patients also had dilated common ducts and this group had the greatest incidence of stones recovered from the duct. Twenty-two per cent of the patients were submitted to choledochostomy because of dilatation of the common duct alone. Only three of these choledochostomies yielded stones. There were eleven patients who had duct exploration for miscellaneous reasons, including lesions of the pancreas, periductal adhesions and the presence of multiple small stones in a gall bladder with a dilated cystic duct. Of these eleven, only one patient had choledocholithiasis. Of the seventy-four common ducts explored, 43 per cent yielded stones. This is comparable to the previously mentioned collective review in which the incidence of common duct exploration was 23 per cent and stones were found in about 50 per cent of the cases explored. It is of interest to note that the average age of those patients having common duct calculi was fifty years, which is in keeping with the reports that the incidence of

choledocholithiasis is greater in the older age groups and greater in those patients having the longest histories of gall-bladder disease.

Morbidity

The incidence of wound and other complications is difficult to evaluate because of the large number of observers involved in writing the progress notes on this number of patients. However, if attention is directed to those patients who were still in the hospital ten days or longer following surgery, some concept of the complications becomes evident. There were seventeen such cases in the cholecystectomy group, nine having wound infections. Of the remaining eight patients, two developed thrombophlebitis, two patients had prolonged copious drainage of bile for eight days, one patient developed a subhepatic abscess and one patient had to be re-operated upon on the second postoperative day for bleeding from the operative site. No source of bleeding was discovered at the second exploration. The wound infections were all related to prolonged operating times of the order of two and one-half hours or more and were evenly distributed between the previously mentioned groupings of acute, subacute and interval cases. Of the seventy-four choledochostomies, there were three complications recorded. Two of these were wound infections and one patient developed a subdiaphragmatic abscess.

Mortality

There were six deaths in the group having cholecystectomy alone. Two patients died of myocardial infarction on the second and third postoperative days, respectively. One patient died of a postoperative intraperitoneal hemorrhage. There was one death due to cerebral embolism in the immediate postoperative period. The patient having traumatic perforation of the gall bladder had, in addition, contusion of the ileum, laceration of the Falciform ligament and multiple fractures. He died nine days after his exploration and cholecystectomy. One death occurred in a patient who had a cholecystectomy performed at the same time that a ventral hernia was repaired. An ileocutaneous fistula developed and the patient died on the twenty-second day following his surgery. The three fatalities accompanying common duct exploration resulted from the following: One of the patients was an aged man who developed pneumonia and died on the twenty-second postoperative day. One patient developed a fistula following an implantation procedure of the common duct into the duodenum. This was performed because a large stone had eroded and necrosed the distal end of the common duct. The patient was re-explored on the sixth postoperative day and died the following day. The final case was an elderly male who was found to have nonresectable carcinoma of the liver at the time of his surgery. He had an episode of hematemesis on the third postoperative day and exsanguinated. The ages of these patients who expired following simple cholecystectomy averaged sixty-four years, the youngest being forty-seven years of age.

Cholecystostomy

The surgical management of the acutely inflamed gall bladder which is operated upon early because of impending gangrene presents two choices of procedure, cholecystectomy or the more conservative cholecystostomy. During this three-year period, there were twenty-five gall-bladder drainage operations in which a tube was placed in the evacuated gall bladder and the abdomen closed. About one-third of these operations were in patients over seventy years of age, and only five were done in those below age fifty. The ratio of females to males was two to one. As might be anticipated, these patients presented problems in anesthesia and the technical removal of an acutely diseased and hyperemic gall bladder wherein identification of the limits of the cystic duct and gall-bladder wall were difficult. There were seven deaths in this small group, a mortality of 28 per cent.

Comment

The treatment applied to the patients presenting presumptive evidence of an acutely inflamed gall bladder at Detroit Receiving Hospital is determined by several factors. Uncontrollable is the fact that in most instances the patient is new to us and has not been seen on a previous hospital admission or followed in the Outpatient Department for symptoms typical of gall-bladder disease. Consequently, a diagnosis of gall-bladder disease without evaluation of previous attacks and subsequent roentgenographic examination is subject to error. The number of such cases which are operated upon is not available in this study be-

cause they are coded under the corrected diagnosis; however, acute inflammations of the pancreas, appendicitis and perforated ulcer are the chief offenders. Fortunately, these relatively few cases are far outweighed by the patients treated by cholecystectomy or cholecystostomy for acute gall-bladder inflammation on the basis of similar history and findings.

For the most part, patients with acute cholecystitis accomapnied by muscle spasm, marked leukocytosis and toxicity arrive at the hospital relatively soon after the onset of the acute episode, often a matter of hours. Elderly patients and patients with a history of no previous attacks interpretable as gall-bladder disease are regarded as immediate candidates for surgical intervention. The elderly individual with a toxic process does not well tolerate prolonged periods of interval observation in order to definitely establish a diagnosis. In the latter group, a history of similar previous attacks presumably is accompanied by the development of adhesions and scarring, thereby lessening the risk of rupture of a gall-bladder empyema. First attacks, on the other hand, are more susceptible to rupture during a period of observation and the indications are therefore toward immediate surgery if the diagnosis has been made and the inflammatory process appears to be progressive.

The majority of potential cholecystectomy patients admitted with symptoms are in a subacute stage. A Levine tube is placed in the stomach for continuous suction, which in effect is a form of biliary decompression. Pain relief, intravenous therapy and repeated observation complete the initial therapy of which the re-evaluation after three to six hours is most important. In a few cases an increasing leukocytosis, tachycardia, fever and persistent muscle spasm are then regarded as indications for surgical intervention. The more frequent hospital course is a subsidence of symptoms and findings over two hospital days with subsequent roentgenographic studies and further evaluation. As is evident in this study, many of these patients are then operated upon within seven days after the subsidence of their symptoms.

Summary

An analysis of 240 patients undergoing cholecystectomy at Detroit Receiving Hospital during the years 1951, 1952 and 1953, is presented. The age of the patients, histories, physical findings and laboratory studies are noted. The roentgenographic examination is evaluated along with the reasons for operating without such examination. Presented are the incidence of cholelithiasis, indications for common duct exploration and the finding of choledocholithiasis. An evaluation of the severity of the inflammatory process at the time of surgery is made. Morbidity and mortality are recorded.

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RADIOIODINE IN DIAGNOSIS AND TREATMENT OF THYROID DISORDERS

(Continued from Page 1460)

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The Routine Postoperative Letter to the Patient

By Walter W. Hammond, Jr., M.D.
Plymouth, Michigan

RECENTLY I had a telephone call from a patient in which she stated that she had been examined in the Department of Gynecology at the University Hospital, and that she was being referred to the Surgery Outpatient Department for an examination of her breasts. Inasmuch as I had removed a tumor from one of her breasts five years ago, she asked what she could tell them about it. I immediately asked her if she had kept the letter I sent her after her surgery, and she replied that she had it. I told her to take it along and show it to the examining physician, that would be all that she would need. The letter to which I referred was as follows:

August 20, 1950

Dear Mrs. W.:

Due to the fact that so many patients have been encountered who do not know what previous operations were performed upon them, it was thought advisable to supply each patient with a short record of her case.

On June 19, 1950, you had an excision of a tumor from the right breast performed under adrocaine anesthesia in my office.

The pathologist's report was as follows:—"A pericanalicular and intracanalicular adenofibroma, which also shows some of the epithelial changes which are found in mastopathia cystica. No malignancy."

Your progress was satisfactory.

Sincerely,
W. W. Hammond, Jr., M.D.

For the past nine years I have sent this type of form letter to all patients with few exceptions. In the case of children, the letter was sent to the mother of the child. Most surgeons tell their patient what procedures they performed a day or two after the operation, but it has been my experience that very few patients remember what was told to them. If they had a cholecystectomy and appendectomy, they do remember that they had a "gall bladder" operation but they do not remember what was said about the appendix. When it is given to them in the form of a letter to be kept, they can refer to it to refresh their memory or show it to another physician for his edification. The terms used in the letter frequently do not mean much to the patient. They ask about them and I try to explain. They are told that the two most important words in the letter are at the end of the report from the pathologist—"No malignancy." Usually the report from the pathologist is edited and abbreviated so that it contains only positive statements and none of the questions raised by the pathologist. In the case of patients who are in the medical profession, the full report from the pathologist is given.

The first paragraph is the same in all of these letters. In the second paragraph the date and place of hospitalization is stated. The date of operation is given along with the list of surgical procedures. An example would be, "You were a patient in Sessions Hospital, Northville, Michigan, from January 4, 1953, to January 15, 1953. On January 5, 1953, you had an appendectomy, right oöphorectomy and right salpingectomy, performed under sodium pentothal and ether anesthesia." In the third paragraph, the report from the pathologist is given, in a similar fashion to the one in the letter to Mrs. W.

The fourth and last paragraph is usually one of these three sentences:

Your convalescence was satisfactory.

or

You were advised to have periodic examinations relative to possible recurrence.

or

The final results of this surgery are unknown inasmuch as you did not keep your last appointment.

Comment

If this letter is shown to another physician, he has most of the pertinent information he needs. If he desires more information, he knows where to get it.

This letter, sent about two months after surgery frequently reminds the patient to make another appointment for the final examination. Sometimes it reminds him to make another payment on his account.

In case of malignancy in which the wife does not wish to tell her husband, which I believe is her prerogative, she is handed the letter at the time of an office visit, although having the letter around the house is like a wife who indulges in a little

(Continued on Page 1493)

Submitted for publication, October 6, 1955.

Prevention of Postoperative Pain in Rectal Surgery

By Eugene Laurisin, M.D.
Detroit, Michigan

POSTOPERATIVE pain following anorectal operations has always been considerably greater and more prolonged than pain after other operations. Many patients are aware of this. Consequently, it is not surprising that the majority of them prefer to put it off and drag around with their trouble for years. This delay often causes a minor ailment to develop into one of a more serious and extensive nature. Therefore, it becomes obvious that any method which will alleviate postoperative pain is of great benefit to mankind.

Much of the distress can be alleviated or completely obviated by the careful employment of local infiltration of long-acting analgesics. General anesthesia, spinal anesthesia and caudal analgesia all have their place in proctology, but they should not be used without supportive prolonged local anesthesia. Every physician who does rectal surgery should become adept in the use of prolonged local anesthesia, so the patients will not suffer needlessly.

It has been claimed that this will produce sloughs due to prolonged stay in the tissues. Experience shows that slough results in most cases from improper technique, like pooling and uneven distribution. With the proper aseptic handling before the injections are made, analgesia is prompt, lasting and uncomplicated.

The analgesia and the concomitant temporary partial incontinence will last from one to four weeks depending on the amount and kind injected and on the extent of the infiltration.

The oil soluble formulas lasts longer but it is more difficult to inject and distribute evenly and deeply. The water soluble preparations give shorter anesthesia and are to be injected more superficially. The finger may be inserted in the rectum to act as guide and guard against penetration of the rectal wall.

Water solubles are being marketed by a number of companies: Merrill of Cincinnati (Diothane), Farnsworth of Chicago (Quinocaine). The oil solubles, which are of a longer-lasting effect, are marketed by Abbott (Zylcain), Ciba (Nupercain in oil), the Columbus Pharmacal Co. (Proctocain ampules) and C. F. Kirk Co. (Rectocain oil soluble anesthetic in ampules).

It is a slow progress from the time when Yeomans, Mathesheimer et al in the New York Polyclinic developed the oil solubles. The conservative group of rectal surgeons is still reluctant to learn and use prolonged anesthesia; however, progress can not be stopped, and this procedure is being encouraged by Yeomans, Mathesheimer and others who followed and modified the solutions while reporting excellent results: Barr, Bacon, Spiesman, Cantor, Lieberman, Coleman and others, just to name a few well-known men of this specialty.

It is to be hoped that the occasional rectal surgeon will familiarize himself with this prolonged anesthesia, especially when it is more suitable and advantageous for all concerned. Economic reasons as well as remote locations from hospitals will give the doctor opportunity to help his patient without hospitalization.

The majority of proctologic problems can be diagnosed and treated by the general practitioner; however, he must always include sigmoidoscopy as part of his routine physical examination. More than one-half of all rectal cancers can be found by digital examination. If the general practitioner is not prepared for a sigmoidoscopy, every patient with or without symptoms should be referred to some one who is so equipped and knows how to do it correctly. Such procedure by the general practitioner or by the proctologist is the single most important factor in the early diagnosis of carcinoma and of premalignant polyps of the lower bowel.

The technique of ambulant proctology makes it possible to handle surgical problems in the well-equipped and well-staffed office often without hospitalization.

Indications for Hysterectomy

By Richard W. TeLinde, M.D.
Baltimore, Maryland

HYSTERECTOMY has become one of the more commonplace operations. It may be one of the simplest operative procedures and it can be one of the most difficult. One can often judge by a careful examination preoperatively the difficulties which he will encounter at the operating table, but not always. Unexpected complications are encountered at operation which, if not properly handled, may increase the morbidity and mortality. Just before the war we performed one thousand successive hysterectomies with two deaths. Both were from pulmonary embolism and probably unavoidable. Nevertheless, in general, the mortality from hysterectomy in the better hospitals is in the neighborhood of one per cent. In addition, there may be a more or less serious morbidity associated with the operation due to bladder, ureteral or bowel injuries. These complications have become more frequent in recent years due to the more universal performance of total hysterectomy. This is not to indicate that I am opposed to total hysterectomy. On the contrary, I believe the total operation is the better procedure and should be done in almost all instances. On our service last year we performed total hysterectomy in 92 per cent of the cases. I hope the incidence will never become 100 per cent for, if it should, I would be forced to the conclusion that the staff had lost its surgical judgment. Our ward service is largely composed of colored women who have large fibroids which are often complicated by salpingitis, and it is sometimes wiser to do the lesser operation because of technical difficulties in removing the cervix. When in the judgment of the operator, the danger of removing the cervix exceeds the danger of cancer occurring in the cervical stump he had better do the subtotal operation.

I have spoken of the difficulties sometimes encountered with hysterectomy not to discourage its performance when there is a sound indication, but to emphasize that it should not be undertaken unless there is a real indication.

Presented at the Annual Session of the Michigan State Medical Society, Grand Rapids, September 29, 1955.

Vaginal Hysterectomy

Within the past several years, vaginal hysterectomy has become increasingly popular with some operators. I think this is proper, for it has definite advantages over the abdominal operation. In general, the postoperative discomfort is less and recuperation is more rapid. My indications for vaginal hysterectomy are few, but they occur with sufficient frequency to make it one of our more frequent operations.

Recurrent functional bleeding of sufficient severity to require definite treatment is one of the more frequent indications. I emphasize *recurrent* bleeding because I believe curettage should always be done first to establish the diagnosis and for its possible curative effect. Under certain circumstances, a second curettage may be advisable, but if the bleeding recurs with sufficient severity to make definitive treatment advisable, vaginal removal of the uterus is the operation of choice. I believe this is true whether the vagina is nulliparous or parous and even when there is no descensus.

The same operation is indicated when one is dealing with a small bleeding fibroid. If the uterus is more than twice its normal size, I believe it is better to remove it abdominally. I am cognizant of the fact that not infrequently a large free fibroid can be removed vaginally quite safely by morcellation in expert hands, but in average hands stunt surgery had best be avoided. The presence of a low midline scar indicating previous pelvic surgery should make one very cautious in selecting vaginal hysterectomy. It is not an absolute contraindication, but one should make quite certain by careful examination under anesthesia that the uterus is freely movable before attempting its removal vaginally. As a matter of fact, it is an excellent plan when doing vaginal hysterectomy to have a table set up for laparotomy for use if difficulties are encountered vaginally requiring quick entrance of the abdomen. I have only once in my career had to make this change, but I believe in that instance it was life saving and hence worth the extra effort of preparedness.

Abdominal suspension of the retrodisplaced uterus is justly being done less and less frequently. I think that this trend is proper, but I happen to believe there is still an occasional indication for an intra-abdominal uterine suspension. Nevertheless, when a woman has really distressing symptoms from retrodisplacement with or without first degree descensus and when she has in her opinion completed her family, I believe a vaginal hysterectomy with the indicated vaginal plastic repair is far superior to an intra-uterine suspension. Relief of symptoms is assured, and further trouble from a diseased uterus is impossible.

This brings up the problem of the more marked degrees of uterine prolapse in relation to vaginal hysterectomy. It may surprise some of you to hear me say that I do not regard it as the operation of choice when there is marked descensus. It does not fall within the domain of this paper to discuss in detail the technical advantages and disadvantages of the various types of operation for prolapse and I will simply state that, after giving vaginal hysterectomy a trial in the treatment of the advanced degrees of prolapse, we found it wanting in too many instances after a long follow-up. A prolapsed vagina occurring after vaginal hysterectomy is extremely troublesome and very difficult to repair if one is to preserve a functional vagina. Our present attitude is that each case of prolapse should be regarded individually and the operation done which is best suited to the case. On the whole, the Spalding-Richardson operation has proved quite satisfactory, and we have reserved the vaginal hysterectomy for those cases of marked prolapse in which benign disease of the uterus makes its removal desirable.

Before leaving the subject of vaginal hysterectomy I should like to say a word about the removal of the grossly normal uterus for severe dysmenorrhea. I have done the operation for this indication perhaps half a dozen times in my professional career and since the uteri are normal in size I have usually done the operation vaginally. In the woman approaching forty or beyond, who has extreme menstrual pain and upon whom all conservative measures have been tried, it does not seem sensible to me to perform presacral neurectomy with perhaps a 70 per cent chance of relief when a hysterectomy can offer her certain relief. I am assuming that such a patient will have had her children without relief of her menstrual pain or that she has given up the idea of childbearing. Some of my most grateful patients fall into this group, but they are few and, if one does the operation in properly selected cases, the number should remain small.

Abdominal Hysterectomy for Benign Uterine Disease

Probably one of the greatest surgical sins of our generation is the unnecessary removal of the asymptomatic myomatous uterus. There are definite indications for removal of the fibroid uterus and one should be satisfied in his own mind that at least one of the following symptoms is present before advising hysterectomy: Excessive bleeding; discomfort or severe pain arising from the tumor; pressure of adjacent organs causing dysfunction, such as the bladder, bowel, or ureter; distortion of the abdomen, or evidence suggesting malignant change.

Myomectomy is indicated at times because of the effect of the fibroid upon past, present or future pregnancies. Since this paper deals only with the indications of hysterectomy, a discussion of myomectomy is not pertinent.

Let us consider the above indications individually. Excessive bleeding at the time of menstruating may be and often is due to fibroids, but excessive bleeding from the fibroid uterus is not necessarily due to the fibroid. Other pathologic lesions, such as endometrial hyperplasia or endometrial polyps, may be the cause and the fibroids may be incidental. After all, how frequently does one encounter even large fibroids with normal or even scanty menstruation? Hence, when menorrhagia has been present only a month or two, a curettage should be done instead of rushing into a hysterectomy. Curettage may accomplish several things. It will remove an endometrial polyp and stop the bleeding. It will remove the hyperplastic endometrium and temporarily or permanently relieve the patient. It will indicate whether the uterine cavity has become irregular due to the submucous position of the fibroid, which information may be of great value in deciding on hysterectomy in the future. By curettage, combined with cervical biopsy, a diagnosis of malignancy can be made or excluded. It is particularly important to carry out this simple diagnostic procedure when there has been intermenstrual bleeding.

Abdominal or pelvic discomfort or more severe pain is a frequent reason for operative interfer-

ence. There are many causes for pain with fibroids; the pressure of a large but uncomplicated tumor on the pelvic nerves may give rise to pain, and tumors which are the site of extensive necrosis are also sometimes painful. In rare instances, pedunculated fibroids twist and give rise to a clinical picture of acute abdominal pain much like one sees with a twisted ovarian tumor. In the author's experience, fibroids twist on their pedicle more often postmenopausally and during pregnancy. The commonest cause for pain in our public ward experience is a complicating pelvic inflammatory disease, acute or chronic. A long-standing pelvic inflammatory residue that has been asymptomatic for months or years may become painful when the growing fibroid begins to stretch the pelvic adhesions. Circulatory disturbances and edema resulting from pressure of the tumor upon chronically infected tubes sometimes results in acute or subacute painful exacerbations. Such pelvic inflammatory disease seldom responds well to palliation, and surgery is necessary sooner or later. Dysmenorrhea, acquired in the fourth or fifth decade, may be the outstanding symptom of the growth of fibroids. A common symptom complex resulting from the fibroids at this time of life is menstrual pain, coupled with increased menstrual flow. Regardless of which one of the above conditions is responsible for the pain, hysterectomy is indicated.

Evidence of pressure on near-by pelvic viscera is also an indication for treatment. The urinary bladder is the organ that suffers most often from such pressure, giving rise to frequency of urination. Although this symptom is common with large fibroids, it is remarkable how frequently one sees the pelvis filled with fibroids without any increased frequency of urination. The great ability of the bladder to function normally in spite of extreme distortion by pelvic tumors is truly remarkable. Occasionally, acute retention of urine results from a fibroid and necessitates surgical interference. We have seen this occur as the result of marked growth of the fibroid anteriorly, pressing the superior surface of the bladder against the internal sphincter region. More frequently a tumor of about the size of a three-months pregnancy incarcerated in the cul-de-sac pushes the cervix downward and forward and obstructs the flow from the urethra. We have also observed a large pedunculated submucous tumor, filling and distending the vagina, pressing on the urethra and causing retention. As stated previously, the presence of the tumor upon the ureters at the pelvic brim, with resultant kidney damage may indicate the necessity of operative treatment.

The bowel is less apt to show symptoms from pressure than the bladder, but constipation can be caused and aggravated by such pressure; more frequently one is astounded by the relatively normal function of the bowel in the presence of large fibroids that almost completely fill the pelvis. Very rarely we have seen acute intestinal obstruction occur from pressure of a large fibroid on the bowel.

Often a large fibroid uterus will give no other symptoms except abdominal distention. No woman should be required to appear as though perpetually pregnant or to have a permanently distorted figure, and I believe this constitutes a reason for hysterectomy even without other symtoms.

When a woman is told that she has a fibroid uterus and is advised that it may be safely kept under observation the natural question is, "What about malignancy?" The chance of fibroids undergoing malignant change is slight. Evans in a large series of fibroids at the Mayo Clinic found sarcomatous change in only 0.7 per cent. Actually the percentage of malignancy in fibroids is much less than that, for this percentage was based on the fibroids removed for proper indications. If the percentage of malignancy could have been based on all existing fibroids (which is obviously impossible), it would have been much smaller. Certain it is that the risk of malignant change is no greater than the risk of surgery in most instances, so the possibility of its occurrence does not constitute a legitimate reason for removal. On the other hand, when there is reason to suspect malignant change because of rapid growth, or any growth after the menopause, hysterectomy is indicated. Rarely, a benign myoma grows after the menopause, but this is so rare that it is only safe to assume that proven postmenopausal growth indicates sarcomatous change and immediate hysterectomy.

Abdominal Hysterectomy with Operation for Adnexal Disease

What are the indications for hysterectomy when surgery is done for adnexal disease? This question should be answered in three parts depending upon whether we are dealing with salpingitis, endometriosis or ovarian tumors.

It is recognized generally today that surgery is usually done for the residue of salpingitis and the resultant pelvic pain, rather than for the elimination of the infection. Even before the advent of the sulfas or antibiotics it was recognized that acute and subacute salpingitis would usually subside with rest, local heat and the passage of time. Only the local complications, such as pelvic abscess, required drainage. But rarely a thick walled tuboovarian abscess, even with thorough antibiotic treatment, persists and requires removal to eliminate the infection. Nevertheless, most surgery today is and should be done for persistent abdominal and pelvic pain due to adhesions resulting from the burned out infection. Since Neisserian tubal infection is practically always bilateral, a double salpingectomy is required, sometimes with the removal of one or both ovaries. With postabortal infection, bilaterality is not as often the rule and if surgery is required a normal tube may at times be spared. When I took over the ward service at Johns Hopkins, I was immediately struck with the number of patients who required further surgery for uterine disease upon whom bilateral salpingectomy had been done several years before. In the sterile woman, the uterus can be nothing but a liability and in recent years it is almost an invariable rule to perform hysterectomy when both tubes are removed. This probability is discussed with the patient preoperatively and, if the patient is adamant in her desire to have her uterus spared, we may yield to her desire. When the tubal disease is tuberculous, hysterectomy is still more important because the uterus frequently is involved with the tuberculous disease.

When the severity of the symptoms requires lapartomy for endometriosis, one may have the choice of conservatism with preservation of the childbearing function, radical surgery and semiradical surgery. By the last named procedure, we mean hystectomy but preservation of at least a portion of one ovary. Naturally the younger the woman and the greater her desire for pregnancy, the harder one attempts to be conservative. Our results with conservative surgery in these young women have been most gratifying. In the woman past forty with extensive involvement of both ovaries with endometriosis, hysterectomy and double adnexectomy are usually the procedures of choice. But there is a group of relatively young women with endometriosis in whom childbearing is past or impossible in whom we have been able to avoid complete castration, but in whom the removal of the uterus should be done to eliminate severe menstrual pain. Although a small percentage of these women may ultimately require radical surgery, the majority of them are kept comfortable by this semiradical procedure.

Abdominal Hysterectomy for Malignant Uterine Disease

There is no place in all surgery when a knowledge of gross pathology is more important than when dealing with ovarian neoplasms. When dealing with unilateral benign tumors in relatively young women, it is obvious that the uterus and opposite ovary should be spared. With benign unilateral tumors in the middle-aged woman approaching her menopause, it is often wiser to remove the opposite adnexa and uterus. With bilateral ovarian cancer there is, of course, no choice but to perform hysterectomy and double adnexectomy. But what of the unilateral, well encapsulated malignant ovarian tumor? Radical surgery is the back bone of the treatment of almost all ovarian malignant ovarian neoplasms. There is a temptation at times to simply remove the affected tube and ovary but the lymphatic connections between the uterus and opposite adnexa are so extensive that radical surgery should be done. Even when the opposite ovary appears normal, microscopic cancer is present in a high percentage of the cases. In fact, if a mistake has been made and a unilateral ovarian neoplasm is removed without removal of the uterus, only to find the tumor malignant on miscroscopic section we believe a second operation should be done without delay for the removal of the uterus and opposite adnexa. There is only one exception which we make to the rule of radical surgery for malignant ovarian tumors. In very young individuals one occasionally encounters a feminizing or masculinizing well encapsulated tumor. Although these tumors are malignant, they are usually of low grade malignancy and a calculated risk of conservative surgery may be taken.

The question of hysterectomy for carcinoma of the corpus uteri is not controversial. All gynecologists in the United States and Canada are agreed that total hysterectomy and bilateral salpingo-oöphorectomy should be done for endometrial cancer. All are not agreed on the advantage of preoperative irradiation. In our clinic, we believe it

is advantageous on the basis of our own experience and an unbiased review of the literature. Recurrences in the vaginal vault appear to be fewer if preoperative intracavitary irradiation is done.

The question of hysterectomy for cervical cancer is very controversial. Opinion is varied not only regarding surgery versus irradiation but there are some who believe a combination of the two should be used. I can only give you our views and attempt to give our reasons for holding them. In selecting therapy for cervical cancer today one should make as exact an estimate as possible as to the extent of the growth. Almost everyone is agreed that stages 3 and 4 of cervical cancer should be treated by irradiation. The results are poor but the only surgical attack possible is by exenteration which has a terrific mortality and still greater morbidity. At the other extreme is Stage O, the preinvasive growths. It is our custom to treat them by surgery. The operation which we do for this stage of the disease is a Modified Wertheim hysterectomy. By this we mean that we remove two or three centimeters of parametrium and a good vaginal cuff, but we do not do a pelvic lymphadenectomy. In our experiment with therapy with this stage of cervical cancer we decided on this type of operation and now have operated upon over two hundred patients within the last twelve years and all are living and well. In addition, since so many of these occur in young women we frequently save an ovary and thus prevent an early menopause. That this is a safe practice is shown by the fact that all of these patients are also well. For these reasons we have continued with this treatment of Stage O.

Most gynecologists concede that Stage 2 of the disease, in which there is extension to the upper vagina and to a slight degree to the parametrium, should be irradiated. The real controversy is concerning Stage 1, when the entire lesion is confined to the cervix. It has been our custom to treat these women with a full course of irradiation. Our five-year salvage has varied in different years from 70 to 85 per cent. Others have treated this group of patients by the radical hysterectomy, adnexectomy and pelvic lymphadenectomy. Their salvage is practically identical to ours but this major surgery is much more of an ordeal for the patient than is the application of radium, and urinary tract complications are more frequent among the surgical cases. In our clinic we reserve this operation for the Stage 1 and occasional early Stage 2 cases which do not respond to irradiation or have local recurrence in the cervix. In deciding the question of irradiation versus surgery, one should always bear in mind that most of the published results are those of expert technicians in pelvic surgery who have had long and constant experience with this operation. The average or even good pelvic surgeon who might be called upon to perform the operation only occasionally had better decide on irradiation even in what appear to be favorable Stage 1 cases.

THE AMERICAN ACADEMY OF ALLERGY

A scientific "Hawaiian Session" of the American Academy of Allergy is scheduled for February 7 to 12, 1957, as a conclusion to the Academy's annual meeting in Los Angeles, February 4 to 6, 1957. An extensive program is planned for February 15, 1957.

Physicians throughout the United States are invited by the Academy to participate in this mid-winter professional and vacation opportunity in the Paradise of the Pacific. Further information can be obtained from the Executive Office of The American Academy of Allergy, 208 E. Wisconsin Ave., Milwaukee 2, Wis.

Fractures of the Humerus

Ambulatory Traction

By Hira E. Branch, M.D.
Flint, Michigan

THE following technique was evolved to allow humeral fractures to heal with better results, at less cost to the patient, as most cases can be handled on an outpatient basis. It is based on the principle of utilizing the weight of the forearm and arm, below the fracture site, as the traction force. This is accomplished by using a wrist neck sling. Added traction force may be obtained by use of a splint forearm cast, and still more traction by adding weights to the forearm cast (Fig. 1).

Procedure

The patient is set up on a table, holding the wrist of the fractured side in supination, the elbow bent at 90 degrees, and in such a manner that the forearm and arm *drag* through the fracture site on the shoulder. It may be necessary to lean slightly toward the fracture side. Very rarely is local anesthetic in the fracture necessary. A two-inch plaster slab is now placed from the base of the neck over the shoulder down the arm to the lateral point of the elbow. This, plus a wrist neck sling, may be all that is necessary for a head or surgical neck fracture. Fractures below this level usually have a posterior plaster slab from the tip of the shoulder to the tip of the olecranon, a slab anteriorly stopping an inch proximal to the elbow crease, and a short fourth slab from the axilla to the inner point of the elbow. These slabs are held on by a gauze bandage over which is placed a snug elastic bandage. After the slabs are bandaged, a wrist neck sling is applied.

The fracture is now set by merely straightening the humerus into good alignment and holding until the plaster splints are hard. Each few days the elastic bandage should be replaced to keep the splints snug.

In fat patients, it is necessary to place a pillow under the axilla, tying it around the neck to hold it in position. The fractured arm is thus held in straight alignment and lateral bowing is prevented. Two or three inch stockinette is useful for the wrist neck sling and to hold the pillow.

Infrequently, a very large traction force is needed in severely impacted or overriding fractures

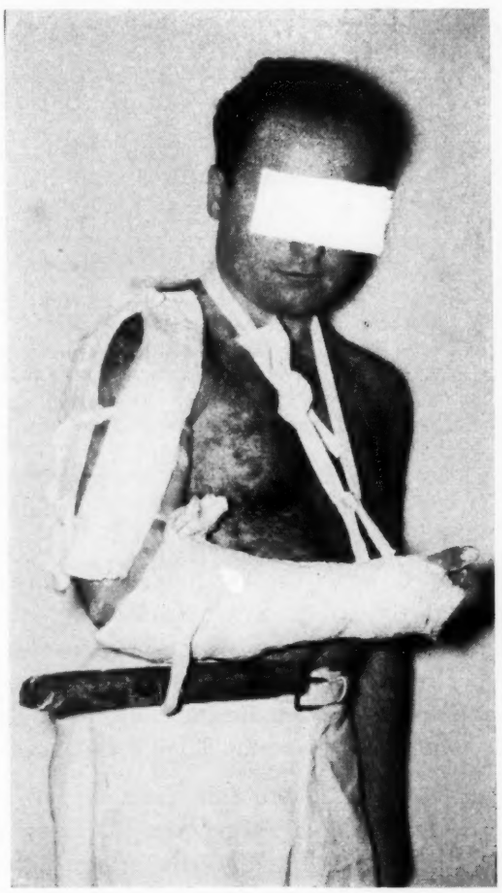


Fig. 1. Coaptation plaster splints and wrist-neck sling. The forearm cast is split and weighted.

(Figs. 2, 3 and 4). In these, a thickly padded forearm cast is applied with a loop at the palm and is immediately split for possible swelling. A neck sling is fastened to the palmar loop. If necessary, a five pound sash weight or pound weights may be added at the elbow level, but these must be removed within twelve to seventy-two hours. The forearm cast is removed in three to ten days.

Presented at the meeting of the American Medical Association, Atlantic City, New Jersey, June 7, 1955.

Distraction of the fracture and luxation of the shoulder may be the penalty should this traction force be left on too long.

Lower-Third.—Radial nerve palsy was found in 8.3 per cent of these patients, dislocation of the elbow in 16.7 per cent, and compound fractures in

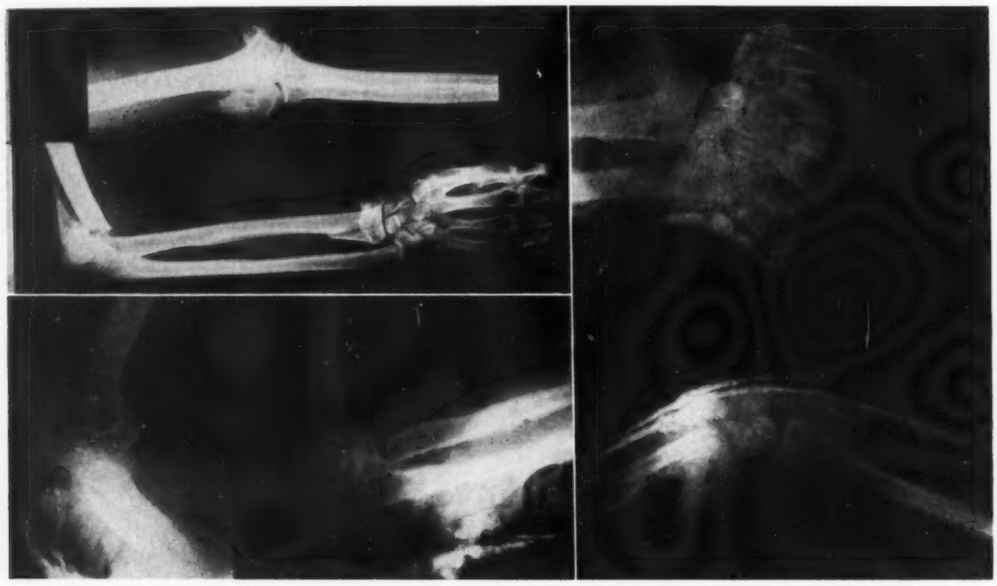


Fig. 2 *(Upper left).* Severe comminuted Y-type condylar-supracondylar and shaft fracture, complicated by Colles type wrist fracture.

Fig. 3 *(Right).* Colles fracture reduced manually under local anesthesia, hold by plaster splints. A weighted forearm cast is then applied for the humeral fracture. (See Figs. 2 and 4).

Fig. 4 *(Lower left).* Humeral fracture reduced in twelve hours by weighted cast. The weights were then removed, and the forearm cast was continued for seven days.

Discussion

Two-thirds of all the 187 humeral fractures involved in this study were treated on an outpatient basis. No hospital stay was involved in 48.6 per cent of the cases. The complications associated with these fractures are illustrated in the six accompanying diagrams (Figs. 5-10).

Head Fractures.—Multiple fractures of other bones were present in 30 per cent of these cases, raising the average to 4.5 days in the hospital. (Fig. 5).

Upper Third and Surgical Necks.—In this group there were only 8.3 per cent multiple fractures of other bones, with 1.6 per cent pathologic (cancer) fractures (Fig. 5), and the average hospital stay is only 2.1 days.

Middle-Third.—Radial nerve palsy was present in 17.6 per cent and ulna nerve palsy in 3 per cent of these patients (Fig. 6). 14.7 per cent of this group had fractures of other bones, resulting in 2.2 days hospitalization.

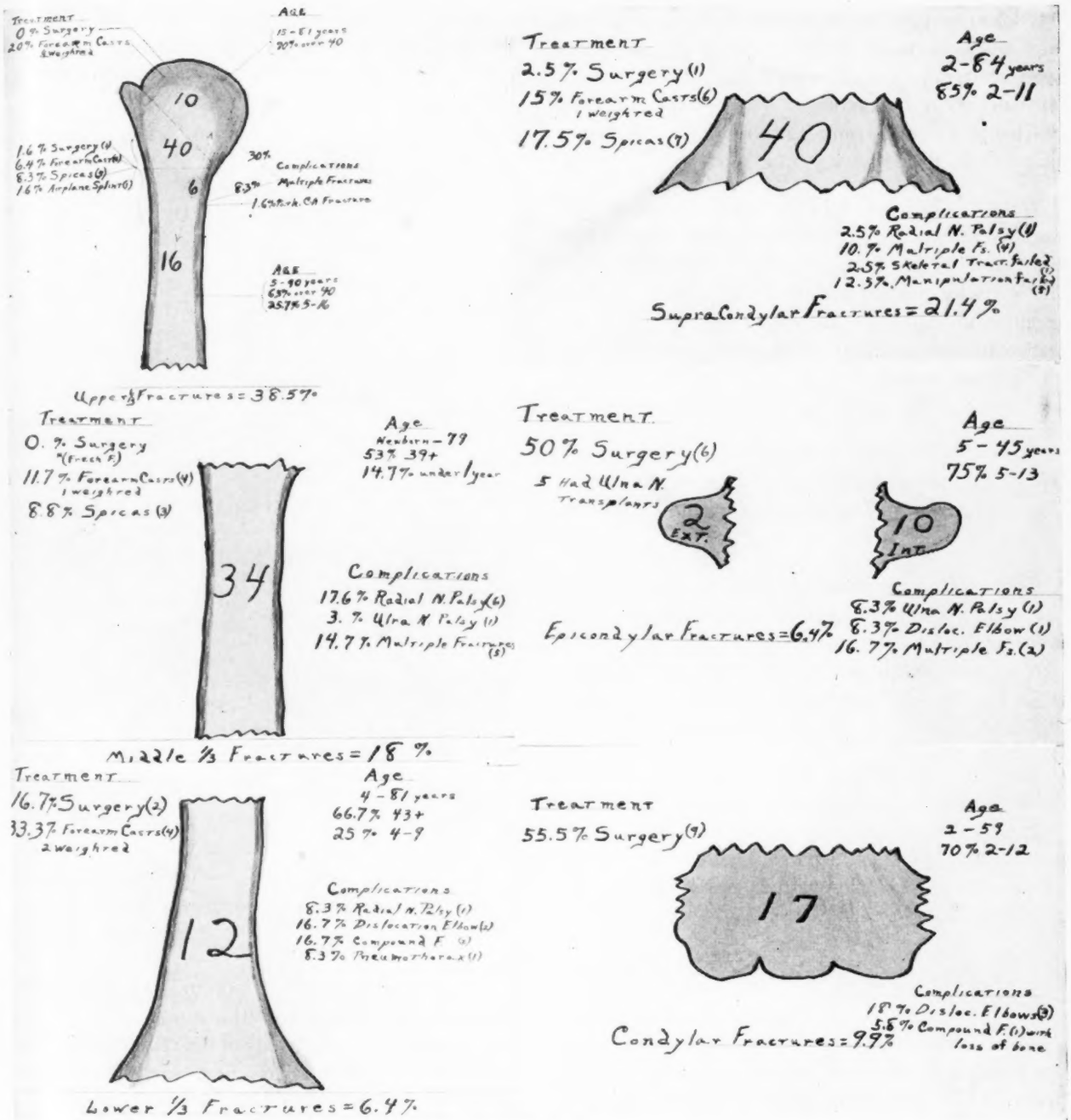
16.7 per cent (Fig. 7). Pneumothorax was present in 8.3 per cent. This group only averaged two days in the hospital.

Supracondylar.—(Fig. 8) Ten per cent of these patients had fractures of other bones, and 2.5 per cent were found to have radial nerve palsy. Skeletal traction had failed in 2.5 per cent and manipulations in 12.5 per cent of these cases. This group only averaged 1.1 days in the hospital.

Epicondylar.—Ulna nerve palsy and dislocation of the elbow occurred equally in 8.3 per cent of these patients, with 16.7 per cent having fracture of other bones. The average hospital stay was 2.6 days. (Fig. 9).

Condylar.—Dislocation of the elbow occurred in 18 per cent of these patients (Fig. 10) and compound fractures in 5.8 per cent, involving actual loss of bone. This group average 2.5 days in the hospital.

Fractures of the head and shaft of the humerus



Figs. 5 to 10.

occurred predominantly in patients over thirty-nine years of age, with supracondylar, epicondylar, and condylar fractures largely in the two to thirteen-year age group (Figs. 5-10 and 11). Patients under one year of age all suffered middle third shaft fractures.

Treatment

Head fractures occurred in ten patients (5.3 per cent) and no surgery was performed. Forearm casts, one-half of which were weighted, were placed on 20 per cent of the cases, with airplane splints on 10 per cent. Exercises of the joints began on the thirtieth day.

Sixty-two patients (33.2 per cent) suffered upper third and surgical neck fractures. Surgery was performed in 1.6 per cent, forearm casts were applied in 6.4 per cent, spica casts in 8.3 per cent, and airplane splints in 1.6 per cent. Exercises of joints and muscles began on the twenty-sixth day.

Middle third fractures involved thirty-four patients (18 per cent). Forearm casts were used in

11.7 per cent with one-fourth of them weighted, and spicas were used in 8.8 per cent. Exercises were started on the thirty-fifth day. There was no surgery of fresh fractures. There were four old fractures, all of the middle third shaft, which are outlined in the following case reports:

Case 1.—This was a non-union, unreduced two-and-a-half weeks' old fracture when the patient first came to me from Florida. There was radial nerve palsy which required from two to five months for recovery. An open reduction was done with an intramedullary nail. Five months later the patient lacked 30 per cent shoulder motion, and the fracture healed on one-half humerus.

Case 2.—This fracture had been treated elsewhere by open reduction and intramedullary nail. The patient had a frozen shoulder when first seen by me months later.

Case 3.—An osteopath had done open reduction and fixation with two wires, a plate, and screws. Radial palsy occurred which cleared in ten months. The patient lacked eight degrees shoulder rotation, and the fracture healed in ten months.

Case 4.—This was a non-union, four months' old fracture which had been operated elsewhere. There was radial nerve palsy, and open bone graft surgery was done and fixation with a Rush pin. The radial nerve was repaired, and there was recovery in six months.

Results

Of 154 patients (81.3 per cent) with fresh fractures of the humerus to the condyles, four (2.5 per cent) were treated by open reduction and twenty (12.7 per cent) were placed in forearm casts, one-fourth of which were weighted. Twenty-nine patients (15.5 per cent) had condylar or epicondylar fractures, fifteen (51.7 per cent) of whom were treated by open reduction. Four patients (3.2 per cent) had old fractures upon arrival, and all were operated.

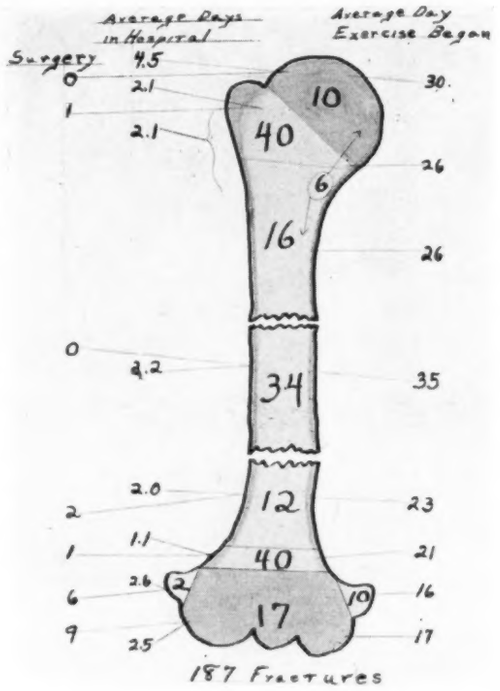


Fig. 11.

Excellent results were obtained in 119 patients (63.6 per cent), good results in thirty-four (18.2 per cent), and poor results in ten (5.3 per cent). Two patients died, and twenty-two (11.8 per cent) did not return for checkup.

Summary

The principle and procedure of ambulatory traction for fractures of the humerus have been presented, and an analysis of 187 consecutive fractures of the humerus has been made. The technique is economically sound, making it possible for two-thirds of the patients to be treated in the office.

MEDICAL JOURNAL PROFITS UNDERGOING TAX SCRUTINY

Internal Revenue Service is making no public acknowledgment of this, but its tax ruling division is looking into profits of a number of medical journals and income taxes paid thereon. Although all of the journals involved are official organs of professional societies, some are handled by book publishing firms.

Michigan Clinical Institute

Michigan physicians engaged in the general practice of medicine, and they are in the majority, are indeed fortunate. Their State Society has officially taken cognizance of their needs by creating the Michigan Clinical Institute. This refresher course held each year in March, combs the entire country in order to secure qualified and interest-holding clinical teachers so that the latest and most practical advances in medicine are made available to the family doctors of Michigan.

The MCI does locally what the AMA Interim Session does nationally. Both place their primary emphasis on speakers and subject matter that appeals to the general practitioners.

In this era of rapid and profound change in both diagnostic procedures and therapeutic armamentarium, the practicing physician, regardless of his specialty—the generalist, in particular—needs not only the efforts and resources of his own special group, but those of his State Society, as well, if he is to attain the degree of proficiency rightly demanded by the public.

It is no mere coincidence that the AMA Interim Session, the AAGP and the MCI, all had their inception in 1947. The force that created them was the ferment of discontent that for years had permeated the minds of the nation's leading generalists. Organized medicine, ever sensitive to the manifest needs of its membership and being essentially democratic, complied with these expressed desires.

Great events tend to occur in multiples, and 1947 marks the acceptance, by all segments of organized medicine, of the fundamental dignity and intrinsic worth of general practice.

The generalist should be reassured and sustained in his difficult but rewarding role of family physician by the realization that his basic position in the over-all medical picture has been fully recognized and heartily approved by both the AMA and the MSMS. In his quest for continuing postgraduate medical education, the generalist should not lose sight of his own State Society's valuable contribution, the Michigan Clinical Institute.

President's

Message

Arch Walls M-D.

President, Michigan State Medical Society

Editorial

HOLIDAY GREETINGS

The Council of the Michigan State Medical Society, the Publication Committee and the Editor bespeak for our membership a most happy Christmas Season, and during the New Year opportunity and courage to accomplish the innermost ambitions for a successful and satisfying tour of duty.

THANK YOU

With this number of THE JOURNAL, we bring the year of 1956 to a close. THE JOURNAL has continued to present the best in medicine from a scientific standpoint. The papers printed have been carefully screened, and many have been definitely stimulated to express the theme the Society or its Committees have especially stressed in that particular number. As in the past ten years, certain special activities or interests have been centered in individual issues of THE JOURNAL and where feasible the covers of THE JOURNAL have been especially designed to set forth the idea. When special groups of papers have been used, the Editor has been happy to have members aid in accumulating and selecting them, stimulating them, or in numerous ways assemble the material for that particular issue. Many men have helped, but we wish to give special credit to a few who have done an outstanding service leading to the complete coverage of some particular phase of our work.

First, we mention J. G. Bielawski, M.D., of Detroit, Secretary of the Michigan Heart Association, who secured most of the papers on Heart Disease and Rheumatism in the January number, and also a group in the May number. For the material in the February number honoring the University of Michigan School of Medicine, we are indebted to Albert C. Furstenberg, M.D., Dean of the Medical School. Gordon E. Scott, Sc.D., Dean of Wayne University College of Medicine, supplied the material for the March number of THE JOURNAL which was devoted to his school. Wayne University also supplied other papers which we have used during the year. John Wellman, M.D., of Lansing, and E. T. Thieme, M.D., Ann Arbor, were of particular help in preparing the April Cancer number. Homer Smathers, M.D., of Detroit, helped with the August Trauma issue, while the September number of THE JOURNAL saluted Ingham County Medical Society for its long-continued and well-attended spring Clinics. William Hayford, M.D., Lansing, was responsible for the many papers being secured for that special number. William LeFevre, M.D., of Muskegon, was again instrumental in securing an offering of most excellent papers on the subject of Diabetes used in the October issue. Hugh W. Brenneman, Public Relations Counsellor, assembled the material making up twenty-eight reports on the several activities of the Medical Profession as Citizens for the November Number of THE JOURNAL.

To all these, we offer our sincere thanks and appreciation of many jobs very well done.

OPHTHALMOLOGIC PRACTICE

Nonmedical practitioners have attempted for several years to place legal restrictions on "eye care" which would limit doctors of medicine from prescribing or furnishing glasses to their patients. Furnishing of glasses is part of "eye care," not the practice of medicine, claim the licentiates of the optometric and optician laws.

Two or three years ago the Judicial Council of the American Medical Association with the knowledge of the leaders of the Ophthalmologic Societies and Section, promulgated the rule: "It is unethical for a physician to profit from the provision of glasses and other appliances. He shall limit the source of his professional income to medical services actually rendered by him to his patient."

At the Atlantic City Session of the American Medical Association in June, 1955, a special meeting of the section was attended by about 800 persons who strongly denounced that opinion of the Judicial Council. The House of Delegates by a decisive vote deleted Section 8 of Chapter 1, and substituted the following: "It is not unethical for physician to prescribe or supply drugs, remedies, or other appliances providing there is no exploitation of the patient."

Many of the state medical societies (including

Michigan) and ophthalmologic societies have officially recognized that "supplying and dispensing of glasses is part of the service a doctor renders his patient in complete eye care."

In October, at the Chicago meeting of the American Academy of Ophthalmology and Otolaryngology, the National Foundation for Eye Care was formed under the auspices of the Academy. The Michigan Trustees are Harold Falls, M.D., of Ann Arbor, and A. D. Reudemann, Sr., M.D., of Detroit.

A revision of the Principles of Ethics of the American Medical Association is now in process, endeavoring to shorten the document. Evidently the same super idealists who influenced the Judicial Council have been at work, for in the proposed revision we read in Section 7: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him to his patient."

Such a statement would include all services rendered in a doctor's office such as x-rays, examinations, laboratory, nurses' services, shots, vaccination, fittings of appliances (glasses) or dispensing of drugs. Do the proposed "principles" indicate a possible deliberate intent to undo the action of last year? These revisions will bear watching.

COMMUNITY HEALTH ASSOCIATION

About three months ago, the Attorney General of Michigan handed down an opinion that a portion of the enabling act under which Michigan Medical Service is organized "is inoperative because the clause is indistinct and not specific." Soon rumors came of a movement to establish another voluntary medical care program under the same enabling act, thus avoiding the establishment of an insurance company.

Early in October, Walter Reuther, President of UAW-CIO, called together a group "of government, business, labor, education and religious leaders" to form a Community Health Association. The purpose of the association would be "to develop a program to make it possible for individuals and families in the community to purchase comprehensive medical care of high quality through pre-payment . . . our plan calls for a different kind and more advanced health service program."

Reuther named the following persons as the founding members of the Association: Rabbi Morris Adler, of Congregation Shaarey Zadek; the Reverend Father John A. Trese, Hospital Coordinator of the Catholic Archdiocese of Detroit; the Reverend Elmer B. Usher, Director of the Department of Christian Social Relations for the Episcopal Diocese of Michigan; James A. Lewis, Vice-President of the University of Michigan in charge of Student Affairs; Wayne County circuit judge, Wade H. McCree, Jr.; Joseph H. Verhelle, Detroit banker; Emil Mazey, UAW Secretary-Treasurer; and Marion Macioce, Vice-President of the Detroit Building Trades Council. Note: not a doctor listed!

Three Detroit hospitals are reported to have agreed to take patients sent in by this Association and allow the doctors to be sent in to treat them. It is also reported that certain doctors have been approached asking them to serve whole or part time on salary. Inducement: Social Security—also hospital facilities.

Doctors and others who have watched the publicity during the past year resulting from the Blue Cross request for increased rates, and the testimony before the Governor's Commission, know that organized labor has an exact program. Reuther has said repeatedly that his ultimate ambition is to force the Congress to pass an act giving "complete health care to the people without expense to the recipient." He and his spokesmen have claimed the services given by Michigan Hospital Service and Michigan Medical Service are not as comprehensive as he wishes, that they are insufficient and too expensive. The Governor's Commission was to find a way to give more complete service at less cost.

The medical profession is still the logical source of prepaid medical care and no program except contract or corporation service can undersell it. The Governor's Commission has failed to find another way even though the Michigan State Medical Society offered every co-operation. We have priced *our* services as low as possible, in fact lower than some of our members are pleased to accept.

MICHIGAN MEDICAL SERVICE OFFERING

In the labor negotiations with Ford Motor Company over a year ago, a $6,000 income limit policy was requested. The Michigan State Medical Society Committee has finally and laboriously

produced such a contract. The cost is high as was expected, but it is available.

Michigan Medical Service has not increased its 1942 rates to consumers since March 1, 1950, when ten cents a month was added, and the $5,000 plan was offered, but has increased services to the patient.

Blue Shield has liberalized its benefits until the margin of reserve is about reached. More liberalization will demand additional premiums. The Board is prepared and hopes soon to announce riders to offer many more services such as office and outpatient diagnosis including laboratory and radiologic services; a rider offering outpatient and office surgery; a rider providing therapeutic radiologic services. This will very materially extend our program, make it more comprehensive and can be done without the necessity of waiting to sell the new $6,000 contract which is also being offered.

HAROLD J. MEIER, M.D.
Councilor 3rd District

To replace the newly elected President-Elect as Councilor from the Third District, the House of Delegates elected Harold J. Meier, M.D., of Coldwater. The doctor was born in Grand Rapids in July, 1904. His early schooling was in Grand Ledge High School and the University of Michigan, College of Literature, Science, and Arts.

He graduated from the University of Michigan School of Medicine in 1929 and interned at Columbia Hospital, Milwaukee Children's and South View Hospitals from 1929 to 1931. He was licensed to practice in 1931, starting in Burlington, Wisconsin, from 1931 to 1936, where he was associated with the Bennett Clinic. In 1936 he located in Coldwater where his practice is now limited to traumatic and industrial surgery.

His practice was interrupted for three years while he served as Surgeon of Special Troops and Medical Inspection in the Armed Forces, in World War II.

He is a Fellow of the American Medical Association and has been a delegate from Branch County to the House of Delegates for ten years. He is Past President of the Branch County Medical Society, a member of the Public Relations Committee of the Michigan State Medical Society since its inception, and other state society committees. He is a member of the American Fracture Association, Association of Military Surgeons, Industrial Medical Association, and Alpha Omega Alpha, Medical Fraternity.

He is a member of the surgical staff at Community Hospital in Coldwater and a consultant in surgery to the New Hospital, State Home and Training School in Coldwater.

His wife is deceased; he has two married daughters.

C. ALLEN PAYNE, M.D.
Councilor 5th District

Dr. Payne was born in Laurium, Michigan, in 1909, received his B.S. degree at Hahnemann College of Science in Philadelphia, his M.D. from Hahnemann Medical College in Philadelphia in 1933, and his M.S. in Pathology at Wayne University in Detroit in 1938. In this same year he was certified in Clinical Pathology and Pathologic Anatomy.

He was senior resident pathologist at Methodist Hospital, Indianapolis, Indiana, from 1934 to 1936, and at Henry Ford Hospital in Detroit from 1936 to 1938. Since 1938 he has been pathologist and Director of Laboratories at Blodgett Memorial Hospital in Grand Rapids.

He served as a lieutenant-colonel in the Medical Corps, as Chief of Laboratory Services of the 17th General Hospital in the United States, North Africa and Italy from 1942 to January, 1946.

From 1950 to 1951, he was a Consultant in Pathology to Percy Jones General Hospital in Battle Creek, and is at present Consultant in Pathology to United Memorial Hospital in Greenville, Sunshine Sanatorium in Grand Rapids, and Mary Free Bed Hospital in Grand Rapids. He is Director of Laboratories and Pathologist at Ferguson Hospital in Grand Rapids.

He is a member of Kent County Medical Society, having served as its president in 1955;

member of Michigan State Medical Society, being on numerous committees and serving as Chairman of the Public Relations Committee from 1950 to 1956; Chairman of Michigan Cancer Co-ordinating Committee from 1954-1956; member of Michigan Pathological Society, having served as secretary-treasurer from 1951 to 1953, and as president in 1955; Founding Fellow of College of American Pathologists; Fellow, American College of Physicians; Fellow, American Society of Clinical Pathologists; member American Medical Association; Chairman, Board of Directors, Executive Committee and Medical Vice-Chairman of Michigan Division of American Cancer Society; Rotarian; Member of Executive Committee of Michigan Association of Blood Banks; and Member of Council of the Michigan State Medical Society.

MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION

A new approach to the work of the Michigan Foundation for Medical and Health Education has just been demonstrated. The officers and trustees of the Foundation have received a check for $5,000 to be used as a loan fund to medical students from Barry County, under the terms of the student revolving fund agreement plan administered by the Foundation.

All concerned are most appreciative of the generosity which prompted the check and believe knowledge of this action may stimulate other societies to take similar action. Besides being a worthy cause, this makes another useful outlet for gift funds, and uses the internal revenue provisions to make our gifts much more substantial. If some interested members of other societies would take the lead, it is surprising what could be done. The Foundation is receptive.

Hormonal therapy is largely applied to carcinoma of the breast and prostate as primary treatment.

* * *

Radiation of multiple myeloma is usually hopeless as far as cure is concerned.

* * *

The value of radiation therapy in the rare angiosarcomas and liposarcomas has not been established.

* * *

Environmental cancer studies must be specifically planned and carried out by personnel interested in and trained for such investigations.

* * *

The goal of cancer research, as in all other human diseases, is prevention.

ROUTINE POSTOPERATIVE LETTER

(Continued from Page 1478)

indiscretion on the side keeping a diary—sooner or later the husband runs across it.

Sending or giving a postoperative letter to a patient should be along the same line of thinking which led to the policy of labeling prescriptions as to contents at the University Hospital, Ann Arbor, Michigan. In the past, physicians have frequently told the patient what they were prescribing and why, but they did not put it in writing.

If we are practicing good medicine, our therapy should stand the scrutiny of anyone, and if we are practicing good surgery our procedures and the report of the pathologist should likewise stand the scrutiny of anyone. Our terms are not familiar to patients and not easily remembered by them. Therefore, putting our remarks in writing should help.

Whether or not the "Postoperative Letter to the Patient" is unique or is in common usage, I do not know. It should help counteract any doubts in a patient's mind about needless surgery, ghost surgeons, et cetera, and should offset stories appearing in newspapers, journals, magazines and digests, because the patients have proof in their letter that their surgery was necessary. It should be good public relations. It might even be a substitute for showing their surgical scar. I know it has been carried as far west as California and as far east as New York.

The preparation of the letter can be done entirely by an office assistant. All the information is in the patient's record. All the surgeon needs to do is put brackets, in pencil, around the parts of the report from the pathologist which he wishes included in the letter. Later he can read and sign the letter before it is mailed.

How many keep their letters, how many file them in the waste basket, how many lose them? This might make an interesting study.

To date I know of no untoward effects from these letters and so far none have led to malpractice suits.

Summary

Don't just tell the patient what operative procedures were performed at the time of his operation and what the pathologist said; put it in writing.

Twenty years hence all patients will keep a fairly complete and fairly accurate medical history on themselves with the help of their physicians.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

ISSUES IN PUBLIC HEALTH IN MICHIGAN

Some of the major issues in public health in Michigan today are presented on this page and will be continued on the Michigan Department of Health page in next month's JOURNAL. These issues will be reflected in budget requests that will be made to the legislature by the Michigan Department of Health for the fiscal year 1957-58.

STATE GRANTS TO LOCAL HEALTH DEPARTMENTS

In spite of the fact that more and more services have been required from local health departments by the state, the state subsidy has barely kept up with the decrease in value of the dollar.

New local activities resulting from recent legislation include licensing and inspection of trailer parks, licensing of septic tank cleaners, control of garbage feeding, reporting of narcotic addicts, hearing screening and administration of vaccines.

Moreover, through administrative action, local health departments now assist in licensing and certifying hospitals, licensing nursing homes and homes for the aged, and inspecting and approving resorts. They co-operate with the Department of Social Welfare, the State Board of Alcoholism, the Child and Adult Guidance Centers and assist the Department of Public Instruction with school lunch evaluation and reviewing school plans.

Basic community health needs are themselves increasing in complexity. There are more babies, more school children in more schools, more older people with problems of home or institution care and increased sanitation difficulties in the wake of swift suburbanization.

Current state aid for local health departments stands at $400,000. It is recommended that $600,000 be considered the minimum consistent with the increased demands being made upon local communities.

LICENSURE OF NURSING HOMES AND HOMES FOR THE AGED

Michigan has, at the present time, 466 nursing homes with 10,987 beds, 105 homes for the aged with 1,678 beds and thirty-five county medical care facilities with 3,296 beds.

Under the 1956 law, transferring the licensing of nursing homes and homes for the aged from the State Welfare Department to the State Health Department, the State Health Commissioner is required to license nursing homes and homes for the aged; to provide for hearings; to establish administrative procedures; to make such inspections as are necessary to carry out the requirements of the act and the rules and regulations authorized under the act and to provide material for guidance of nursing homes and homes for the aged in complying with the act and the rules and regulations.

Under a 1954 law, the State Health Commissioner is required to inspect and approve county medical care facilities.

To carry out the duties prescribed by the two laws, funds will be requested by the Michigan Department of Health from the 1957 Legislature to provide for the employment of three nurse consultants, a dietitian, an engineer and a typist. These staff members will work with and through local health departments in carrying out the inspecting, licensing and other services defined by law for the institutions now operating and for the many others which will be opening within the year.

POST-SANATORIUM HOME CARE FOR TUBERCULOSIS

High in priority among the changing needs in the tuberculosis control program is that of continuing and expanding supervised post-sanatorium home care to prevent relapse.

In the past, as many as three of every ten tuberculosis patients discharged from the hospital later returned, their disease again active. Most patients now leaving Michigan's twenty-one public-supported sanatoriums continue treatment with the newer medications at home. As a rule, twelve to eighteen months of carefully supervised treatment is recommended following discharge from the hospital.

The local health department is the community agency best suited to give this supervision. It is recommended that state assistance in financing approved post-sanatorium home care be given to the local health departments, based on the estimated costs of the service. The subsidy for state-at-large and county charge patients would be in approximately the same ratio as that paid by the state for the hospital care of tuberculosis patients.

Home care subsidy also may make return to home possible for some patients who would otherwise spend the rest of their lives in the sanatorium. These patients have tuberculosis in chronic form and cannot expect to control their disease completely. In many cases, supervised treatment holds the disease sufficiently in check so that the patient is not a public health hazard. Under the proposed supervised home care program it is likely that a number of chronically ill patients can safely rejoin their families.

Human anatomy continues to be the biggest obstacle to the cure of cancer of the esophagus.

* * *

In early cancer of the prostate, there are absolutely no cystoscopic changes.

* * *

The opinion of a layman, as to whether he has cancer, or whether he has been cured, is entitled to little, if any, weight.

* * *

Ovariectomy effects regression of approximately 20 per cent of mammary cancers.

Michigan Clinical Institute

Sheraton-Cadillac Hotel, Detroit

Wednesday-Thursday-Friday, March 13-14-15, 1957

Otto O. Beck, M.D., Birmingham, *Chairman*

Information

- **HEADQUARTERS**—Sheraton-Cadillac Hotel; Assemblies and Exhibits on Fourth Floor; Press Room on Fifth Floor.

- **REGISTER**—Top of stairs—Fifth Floor—as soon as you arrive.

  Hours: Tuesday, March12—1:00 p.m. to 5:00 p.m.
  Wednesday, March 13—7:30 a.m. to 5:15 p.m.
  Thursday, March 14—8:15 a.m. to 5:15 p.m.
  Friday, March 15—8:15 a.m. to 3:30 p.m.

- **NO REGISTRATION FEE** for Members of MSMS and other State Medical Associations, AMA, and Canadian Medical Association.

- **ADMISSION BY BADGE ONLY** to all Assemblies and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership Card to expedite registration.

- **GUESTS**—Members of any state medical association, AMA, or CMA members from any province of Canada and physicians of the Army, Navy, and U. S. Public Health Service are invited to attend as guests. No registration fee. Please present credentials at the Registration Desk.

  Bona fide doctors of medicine who are associate or probationary members of Michigan county medical societies or who are serving as residents or interns, if vouched for by the president or secretary of the county medical society in whose jurisdiction they practice, will be registered as guests, with no registration fee. Please present credentials at the Registration Desk.

- **MICHIGAN DOCTORS OF MEDICINE,** in practice but who are not members of MSMS, if listed in the American Medical Association Directory, may register as guests upon payment of $25.00. This amount will be credited to them toward dues in the Michigan State Medical Society FOR 1957 ONLY, provided they subsequently are voted into membership by the county medical society in whose jurisdiction they practice.

- **DOCTOR,** register Tuesday, to save your time! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday-Thursday-Friday, during the 1957 Michigan Clinical Institute. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.

  We recommend to Detroit physicians—and those who arrive in Detroit on Tuesday—that they register Tuesday, March 12, from 1:00 to 5:00 p.m., Fifth Floor, Sheraton-Cadillac Hotel.

- **TELEPHONE SERVICE**—Local and long distance telephone service will be available in the Sheraton-Cadillac Hotel, fourth floor. In case of emergency, physicians will be paged from the meetings by an announcement on the screen. Call the Sheraton-Cadillac Hotel, Detroit, WOodward 1-8000, and ask for the Michigan Clinical Institute extensions on the fourth floor.

- **CHECKROOM** is available in the Sheraton-Cadillac Hotel, fourth floor, next to Grand Ballroom.

- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Committee on Arrangements. This request is made in order to avoid confusion and disappointment on the part of members of the audience.

- **PAPERS WILL BEGIN AND END ON TIME**—Nothing makes a scientific meeting more attractive than by-the-clock promptness and regularity; therefore, all meetings and panels will open on time, all speakers will be required to begin their talks exactly on time and to close exactly on time, in accordance with the schedule in the Program. All who attend the Institute, are respectfully requested to assist in attaining this end by noting the schedule carefully and by being in attendance accordingly, in order not to miss that portion of the program of greatest interest.

- **TECHNICAL EXHIBITS**—Seventy-four (74) interesting and instrucitve displays—will open daily at 8:15 a.m. and close at 5:15 p.m., except on Friday when the exhibit breaks up at 3:30 p.m. Frequent intermissions to view the exhibits have been arranged daily before, during and after the assemblies.

- **THE SCIENTIFIC EXHIBIT** will be located in the Reception Room, adjoining the Grand Ballroom, fourth floor, Sheraton-Cadillac Hotel.

- **THERE IS SOMETHING** of interest or education in the large exhibit of technical displays. SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN CLINICAL INSTITUTE.

- **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Michigan Clinical Institute. Notify J. M. Sheldon, M.D., Chairman, MSMS Committee on Postgraduate Medical Education, 1313 E. Ann St., Ann Arbor, Michigan.

- **PARKING**—Do not park on Detroit's streets. Inside parking at a convenient distance from the Sheraton-Cadillac Hotel is available at the Book Tower Garage, 333 State, the DAC Garage, 1754 Randolph, and the Grand Circus Garage, 1776 Randolph.

- **INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan Clinical Institute. All subjects on the Institute Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

MUCH THAT IS NEW AND INTERESTING WILL BE FOUND IN THE MCI EXHIBIT

• **PRESS RELATIONS COMMITTEE** for the 1957 Michigan Clinical Institute: A. B. Gwinn, M.D., Hastings, Chairman; H. F. Dibble, M.D., Detroit; L. R. Leader, M.D., Detroit; J. J. Lightbody, M.D., Detroit; Ralph W. Shook, M.D., Kalamazoo, and C. L. Weston, M.D., Owosso.

• **COMMITTEE ON COLOR TELEVISION:** Dan W. Myers, M.D., Detroit, Chairman, E. S. Hoffman, M.D., Detroit, F. B. Levagood, M.D., Detroit and E. B. Miller, M.D., Detroit.

• **OTTO O. BECK, M.D.,** Birmingham, is General Chairman of Arrangements for the 1957 Michigan Clinical Institute.

• **G. B. SALTONSTALL, M.D.,** Charlevoix, is Chairman of Committee on Arrangements for Testimonial Luncheon Honoring Presidents of National Medical Organizations on Thursday, March 14.

• **WM. M. LeFEVRE, M.D.,** Muskegon, is Chairman of the Program Committee for the 1957 Michigan Clinical Institute.

THE "BLOCK SYSTEM"

at the

1957 MICHIGAN CLINICAL INSTITUTE

Surgery and Cancer Control—Wednesday morning, March 13

Trauma—Wednesday afternoon, March 13

Heart and Rheumatic Fever—Thursday morning, March 14

Internal Medicine—Thursday afternoon, March 14

Obstetrics, Gynecology and Pediatrics—Friday morning, March 15

General Medicine—Friday afternoon, March 15

• **MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS**

Tuesday, March 12, 1957

1. **Michigan Branch, American Academy of Pediatrics** will hold a Clinical Conference beginning at 2:00 p.m. at the Children's Hospital, Detroit. Reception and dinner beginning at 5:30 p.m. in the English Room of the Sheraton-Cadillac Hotel. The dinner will be followed by a meeting and speaker.

2. **Michigan Chapter, American College of Surgeons:** Annual Meeting will be held at St. Joseph Mercy Hospital, Ann Arbor. Registration: 9:00-10:00 a.m.; scientific program at 10:00 a.m.; luncheon at 12:00 noon; afternoon scientific program begins at 1:30 p.m.; cocktails and dinner begin at 5:00 p.m.

Wednesday, March 13, 1957

3. **Cancer Luncheon** honoring L. Henry Garland, M.D., San Francisco, California, and Charles B. Huggins, M.D., Chicago, Illinois, English Room, Sheraton-Cadillac Hotel.
4. **Michigan Regional Committee on Trauma, American College of Surgeons,** will hold a luncheon-meeting in the Sheraton Room, Sheraton-Cadillac Hotel.

Thursday, March 14, 1957

5. **Testimonial Luncheon** honoring Presidents of National Medical Organizations: J. S. DeTar, M.D., Milan; Cameron Haight, M.D., Ann Arbor; Wilbert G. Malcolm, Ph.D., Pearl River, New York; Rupert C. L. Markoe, M.D., Detroit; N. F. Miller, M.D., Ann Arbor; R. L. Novy, M.D., Detroit; Charles G. Johnston, M.D., Detroit; and Wm. Robinson, M.D., Ann Arbor, in the English Room of the Sheraton-Cadillac Hotel.

6. **Michigan Heart Association:** Annual Meeting. Howard B. Sprague, M.D., Boston, Massachusetts, internationally known cardiologist and a Past President of the American Heart Association, will moderate a panel on "The Heart Patient at Work" during the Michigan Clinical Institute on Thursday morning, March 14, 1957. Dr. Sprague will appear as a guest of the Michigan Heart Association during the Heart Block portion of the MCI. Other members appearing on the panel are: Earle A. Irvin, M.D., Dearborn; Myrton S. Chambers, M.D., Flint; Gordon B. Myers, M.D., Detroit; Marion W. Jocz, M.D., Detroit; and John G. Bielawski, M.D., Detroit.

   Dr. Sprague will also be the featured guest speaker at the Annual Meeting (dinner) of the Michigan Heart Association on Thursday evening, March 14, Grand Ballroom. The dinner-meeting is a slight departure from the usual Annual Meeting format and everyone is cordially invited to attend whether or not he is a member of the Heart Association.

7. **The annual Hickey Memorial Lecture** will be given by John Caffey, M.D., Professor of Radiology, Columbia University Medical School, New York. It will be held on Thursday, March 14, 1957, 8:30 p.m. at the Wayne State University College of Medicine Auditorium, 645 Mullet St., Detroit.

   This lecture is given under the auspices of the Detroit Roentgen Ray and Radium Society, the Wayne County Medical Society, and the Wayne State University College of Medicine.

   Dr. Caffey's subject will be "The Skeleton in Cooley's Anemia."

8. **The Michigan Proctologic Society** will hold a meeting (details to be announced).

Friday, March 15, 1957

9. **A testimonial luncheon** honoring the pharmaceutical lecturer (to be selected), sponsored by the Michigan State Pharmaceutical Association, will be held in the Pan American Room, Sheraton-Cadillac Hotel.

10. **A Conference for Residents, Interns and Senior Medical Students** is scheduled for the English Room of the Sheraton-Cadillac Hotel, beginning at 2:30 p.m.

• **ACKNOWLEDGMENTS**—The Michigan Clinical Institute gratefully acknowledges the co-operation of

1. The Michigan Regional Committee on Trauma, American College of Surgeons, sponsor of the trauma program (three speakers) on Wednesday, March 13.

2. The Michigan Heart Association, sponsor of the heart and rheumatic fever program (seven speakers) on Thursday, March 14.
3. The Michigan Foundation for Medical and Health Education, Inc., sponsor of Charles B. Huggins, M.D., Chicago, the Foundation Lecturer.
4. The Michigan Cancer Coordinating Committee, sponsor of L. Henry Garland, M.D., San Francisco, California, the MCCC Lecturer.
5. Davis & Geck, Inc., Danbury, Conn., for sponsorship of the color motion pictures shown during the MCI in the Normandie Room, Sheraton-Cadillac Hotel.
6. Smith Kline and French Laboratories, Philadelphia, for sponsorship of the color television program beamed to the MCI meeting room; and Detroit's Grace Hospital and its medical staff for cooperation in arranging and producing the 3-days' TV scientific presentations.
7. The Michigan State Pharmaceutical Association for sponsoring the testimonial luncheon honoring the Pharmaceutical Lecturer.
8. Michigan Medical Service, for contributing notepads for use of MCI registrants.
9. Mead Johnson and Co. of Evansville, Indiana, and the Michigan State Medical Society—co-sponsors of the Conference for Residents, Interns and Senior Medical Students.

COMMITTEE ON ARRANGEMENTS

OTTO O. BECK, M.D., Birmingham, *General Chairman*
ARCH WALLS, M.D., Detroit, *President, Michigan State Medical Society*
W. S. JONES, M.D., Menominee, *Immediate Past President, Michigan State Medical Society*
L. FERNALD FOSTER, M.D., Bay City, *Secretary*
Representing Michigan State Medical Society

* * *

J. M. SHELDON M.D., Ann Arbor
A. C. FURSTENBERG, M.D., Ann Arbor
H. F. FALLS, M.D., Ann Arbor
R. M. NESBIT, M.D., Ann Arbor
Representing University of Michigan School of Medicine and University of Michigan Department of Postgraduate Medicine

* * *

J. G. BIELAWSKI, M.D., Detroit
H. M. FULLER, M.D., Detroit
P. C. GITTINS, M.D., Detroit
N. M. TAYLOR, M.D., Detroit
Representing Wayne County Medical Society and Wayne University College of Medicine

* * *

P. H. ENGLE, M.D., Olivet
J. H. FYVIE, M.D., Manistique
D. W. THORUP, M.D., Benton Harbor
J. M. WOOD, M.D., Mt. Pleasant
J. F. BEER, M.D., St. Clair
M. M. HANSEN, M.D., Greenville
F. J. BUSCH, M.D., Saginaw
J. W. LOGIE, M.D., Grand Rapids
R. L. THIRLBY, JR., M.D., Traverse City
Representing Out-State Practitioners, Members of the Michigan State Medical Society

* * *

A. E. HEUSTIS, M.D., Lansing
J. D. MONROE, M.D., Pontiac
Representing Michigan Department of Health and Michigan Health Officers Association

* * *

E. I. CARR, M.D., Lansing
Representing Michigan Foundation for Medical and Health Education

S. E. CHAPIN, M.D., Dearborn
Representing Michigan Heart Association

* * *

V. C. ABBOTT, M.D., Pontiac
Representing American College of Surgeons Regional Committee on Trauma

* * *

C. ALLEN PAYNE, M.D., Grand Rapids
Representing Michigan Cancer Coordinating Committee

COMMITTEE ON PROGRAM

WM. M. LEFEVRE, M.D., Muskegon, *Chairman*
WM. S. REVENO, M.D., Detroit, *Vice Chairman*
C. E. BADGLEY, M.D., Ann Arbor
B. E. BRUSH, M.D., Detroit
J. S. DETAR, M.D., Milan
PAUL DE KRUIF, PH.D., Holland

COMMITTEE ON COLOR TELEVISION

D. W. MYERS, M.D., Detroit, *Chairman*
E. S. HOFFMAN, M.D., Detroit
F. B. LEVAGOOD, M.D., Detroit
E. B. MILLER, M.D., Detroit

HOTEL RESERVATIONS
MICHIGAN CLINICAL INSTITUTE
Detroit, March 13-14-15, 1957

The reservation blank below is for your convenience in making your hotel reservation in Detroit. Please send your application to Mrs. B. Van De Keere, Assistant Sales Manager, Sheraton-Cadillac Hotel, Detroit 31, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

Committee on Hotels
Michigan Clinical Institute
c/o Sheraton-Cadillac Hotel
Detroit 31, Michigan

Attention: Mrs. B. Van De Keere, Assistant Sales Manager

Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving March .....hour.....A.M.....P.M.....

Leaving March .....hour.....A.M.....P.M.....

Hotel of First Choice: .....

Second Choice: .....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....	.....	.....	.....
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.....	.....	.....	.....

Date ..... Signature .....

Address ..... City .....

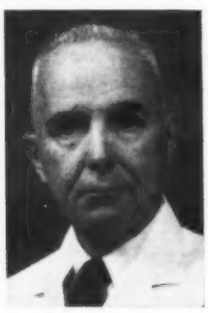
Michigan Clinical Institute
1957

OTTO O. BECK, M.D.

OTTO O. BECK, M.D., Birmingham, General Chairman of Arrangements for the 1957 Michigan Clinical Institute, Detroit. Doctor Beck is Past President of the Michigan State Medical Society.

J. H. GARLOCK, M.D.

L. HENRY GARLAND, M.D.



CHARLES B. HUGGINS, M.D.

Program

WEDNESDAY, MARCH 13, 1957

A.M.

7:30 REGISTRATION—Top of Stairs, Fifth Floor, Sheraton-Cadillac Hotel

8:15 EXHIBITS OPEN—Fourth Floor, Sheraton-Cadillac Hotel

FIRST ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel
Chairman: OTTO O. BECK, M.D., Birmingham
Secretary: JAMES B. BLODGETT, M.D., Detroit

8:20 WELCOME
ARCH WALLS, M.D., Detroit
President, Michigan State Medical Society
L. R. LEADER, M.D., Detroit
President, Wayne County Medical Society

SURGERY—CANCER CONTROL

8:30 "Present-day Approach to the Surgical Therapy of Non-specific Ulcerative Colitis"
JOHN H. GARLOCK, M.D., New York, New York
Director of Surgery, Mt. Sinai Hospital; Clinical Professor of Surgery, Columbia University

9:00 Speaker to be announced

9:30 THE MICHIGAN CANCER CO-ORDINATING COMMITTEE LECTURE
"The Pursuit of the Unorthodox"
L. HENRY GARLAND, M.D., San Francisco, California
Clinical Professor of Radiology, Stanford University Medical School; Visiting Radiologist in charge of Stanford Service, San Francisco Hospital; Chairman, Committee on Cancer Diagnosis and Therapy, National Research Council; Past President, Radiological Society of North America; Consultant Radiologist, Veterans Administration, U. S. Army

10:00 THE MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION LECTURE
"Control of Human Cancers by Endocrinologic Methods"
CHARLES B. HUGGINS, M.D., Chicago, Illinois
Director, The Ben May Laboratory for Cancer Research, University of Chicago

10:30 End of First Assembly

10:30 INTERMISSION TO VIEW EXHIBITS

11:15 to 12:45 **COLOR TELEVISION PROGRAM,** beamed to the Grand Ballroom, Sheraton-Cadillac Hotel through the co-operation of the staff of The Grace Hospital, Detroit and Smith, Kine and French Laboratories of Philadelphia.

OPERATIVE CLINICS

A. Operating Rooms of Grace Hospital

Under supervision of ELMER B. MILLER, M.D., Detroit, Associate Attending Surgeon at Grace Hospital and Instructor in Surgery, Wayne State University

1. **"Cholecystectomy and Bile Duct Exploration"**
   NICHOLAS GIMBEL, M.D., Detroit, Associate Professor of Surgery, Wayne State University, College of Medicine
2. **"Gastric Resection"**
   WILLIAM S. CARPENTER, M.D., Detroit, Harper and Mt. Carmel Hospitals and Instructor in Surgery at Wayne State University

B. Grand Ballroom, Sheraton-Cadillac Hotel

1. **Surgical Commentator and Moderator**
   MARION S. DEWEESE, M.D., Ann Arbor, Associate Professor of Surgery, University of Michigan; Chief of Surgical Services, Ann Arbor Veterans Administration Hospital.
2. **Panel of Discussants**
   CHARLES G. JOHNSTON, M.D., Detroit
   Professor of Surgery, Wayne State University College of Medicine
   RUSSELL L. MUSTARD, M.D., Battle Creek
   Chief of Surgery, Leila Post Montgomery Hospital; Consultant to Percy Jones Hospital and Lecturer in Surgery, University of Michigan
   JAMES W. LOGIE, M.D., Grand Rapids
   Consultant to St. Mary's and Blodgett Hospitals; President, Michigan Chapter, American College of Surgeons

12:45 **End of Television Program**

SECOND ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: DONALD F. KUDNER, M.D., Jackson
Secretary: EMIL J. LAURETTI, M.D., Muskegon

TRAUMA

P.M.

2:00 **"Whip Lash Injuries"**

FRANK H. MAYFIELD, M.D., Cincinnati, Ohio

Chairman, Department of Neurosurgery: The Christ Hospital, and Good Samaritan Hospital, Cincinnati; Member, Board of Directors, University of Cincinnati; Member, American Board of Neurological Surgery; Councilor, Ohio State Medical Association; Vice Chairman, Section on Nervous and Mental Diseases, American Medical Association; Chairman, Subcommittee on Crash Injury Prevention, Committee on Trauma, American College of Surgeons

2:30 **"The Medical Aspects of Highway Accidents"**

RALPH C. MOORE, M.D., Omaha, Nebraska
Associate Radiologist, Nebraska Methodist Hospital; Professor of Radiology, University of Nebraska College of Medicine

CHARLES L. MARSH, M.D., Valley, Nebraska
Physician and Surgeon

3:00 **INTERMISSION TO VIEW EXHIBITS**

ELMER B. MILLER, M.D.

WILLIAM S. CARPENTER, M.D.

CHARLES G. JOHNSTON, M.D.

J. W. LOGIE, M.D.

NICHOLAS GIMBEL, M.D.

M. S. DEWEESE, M.D.

RUSSELL L. MUSTARD, M.D.

RALPH C. MOORE, M.D.

CHARLES L. MARSH, M.D.

F. A. Coller, M.D.

Donald E. Cassels, M.D.

Howard B. Sprague, M.D.

John G. Bielawski, M.D.

Myrton S. Chambers, M.D.

Earle A. Irvin, M.D.

Marion W. Jocz, M.D.

Gordon B. Myers, M.D.

4:00 SURGERY PANEL

Moderator: Frederick A. Coller, M.D., Ann Arbor
Professor of Surgery and Chairman of the Department of Surgery, University of Michigan Medical School

Participants:
L. Henry Garland, M.D., San Francisco, California
John H. Garlock, M.D., New York City
Charles B. Huggins, M.D., Chicago, Illinois
Charles L. Marsh, M.D., Valley, Nebraska
Frank H. Mayfield, M.D., Cincinnati, Ohio
Ralph C. Moore, M.D., Omaha, Nebraska

5:00 End of Second Assembly

No Michigan Clinical Institute Meeting Wednesday Evening

THURSDAY, MARCH 14, 1957

A.M.
8:15 REGISTRATION—Top of Stairs, Fifth Floor

EXHIBITS OPEN—Fourth Floor

THIRD ASSEMBLY
EIGHTH ANNUAL MICHIGAN HEART DAY

Sponsored by Michigan Heart Association

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: E. A. Irvin, M.D., Dearborn
Secretary: Robert E. Fisher, M.D., Battle Creek

HEART AND RHEUMATIC FEVER

8:30 "Rheumatic Fever"

Donald E. Cassels, M.D., Chicago, Illinois
Professor, Department of Pediatrics, University of Chicago Medical School

9:00 Panel on "The Heart Patient at Work"

Moderator: Howard B. Sprague, M.D., Brookline, Massachusetts

Lecturer on Medicine, Harvard Medical School; Member of Board of Consultation, Massachusetts General Hospital; Past President, American Heart Association

Participants:

John G. Bielawski, M.D., Detroit
Medical Director, Michigan Heart Association

Myrton S. Chambers, M.D., Flint
President-Elect, Michigan Heart Association; Cardiologist at McLaren General Hospital; Board of Directors, American Heart Association

Earle A. Irvin, M.D., Detroit
President, Michigan Heart Association; Medical Director, Ford Motor Company

Marion W. Jocz, M.D., Detroit
Medical Director, Chrysler Corporation

Gordon B. Myers, M.D., Detroit
Professor of Medicine, Wayne State University College of Medicine

10:30 INTERMISSION TO VIEW EXHIBITS

11:15 to 12:45 **COLOR TELEVISION PROGRAM,** beamed to the Grand Ballroom, Sheraton-Cadillac Hotel through the co-operation of the staff of The Grace Hospital, Detroit and Smith, Kline and French Laboratories of Philadelphia.

11:15 **"Management of Hypertension"**

FLOYD B. LEVAGOOD, M.D., Detroit
Associate Attending Physician, Grace Hospital; Instructor in Medicine, Wayne State University

11:45 **Clinic on "Endocrine Diseases"**

WILLIAM O. MADDOCK, M.D., Detroit
Associate Professor of Medicine, Wayne State University College of Medicine

12:15 **Clinic on "Collagen Diseases"**

ALFRED JAY BOLLET, M.D., Detroit
Assistant Professor of Medicine, Wayne State University College of Medicine

12:45 **End of Television Program**

F. B. LEVAGOOD, M.D.

WILLIAM O. MADDOCK, M.D.

FOURTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: MUIR CLAPPER, M.D., Detroit
Secretary: WM. M. LEFEVRE, M.D., Muskegon

INTERNAL MEDICINE

P.M.

2:00 **"Some Problems of Gerontology"**

WM. B. KOUNTZ, M.D., St. Louis, Missouri
Assistant Professor of Clinical Medicine, Washington University School of Medicine and Director of Clinical Research, Division of Gerontology

2:30 **"Sudden Unexpected Death"**

JULIUS BAUER, M.D., Los Angeles, California
Clinical Professor of Medicine, College of Medical Evangelists, Los Angeles; Senior Attending Physician, Los Angeles County General Hospital; Consultant, VA Hospital, Long Beach, California

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Black and Blue Spots"**

WILLIAM DAMESHEK, M.D., Boston, Massachusetts
Senior Physician and Hematologist-in-Chief, New England Center Hospital; Professor of Medicine, Tufts University School of Medicine, Boston

4:30 **"Animal Health and Human Welfare"**

JAMES H. STEELE, D.V.M., M.P.H., Atlanta, Georgia
Chief, Veterinary Public Health Activities, Communicable Disease Center, Consultant: World Health Organization, U. S. Defense Dept. and State Department, American Board of Veterinary Public Health, (Founder), Conference of Public Health Veterinarians (Founder), American Public Assn. (Governing Council), National Board of Veterinary Medical Examiners (Executive Board), National Brucellosis Committee (Executive Board), Military Surgeons Association, U. S. Livestock Sanitary Assn., XV International Veterinary Congress (Plenary Speaker).

5:00 **End of Fourth Assembly**

No Michigan Clinical Institute Meeting Thursday Evening

WILLIAM B. KOUNTZ, M.D.

JULIUS BAUER, M.D.

WILLIAM DAMESHEK, M.D.

JAMES H. STEELE, D.V.M., M.P.H.

NORMAN F. MILLER, M.D.

EDWARD F. SLADEK, M.D.

WILLIAM M. LEFEVRE, M.D.

G. S. FISHER, M.D.

HAROLD D. DYKHUIZEN, M.D.

C. PAUL HODGKINSON, M.D.

CECIL W. LEPARD, M.D.

FRIDAY, MARCH 15, 1957

A.M.

8:15 REGISTRATION—Top of Stairs, Fifth Floor
EXHIBITS OPEN—Fourth Floor

FIFTH ASSEMBLY
Grand Ballroom, Sheraton-Cadillac Hotel
Chairman: HAROLD A. FURLONG, M.D., Pontiac
Secretary: BROOKER L. MASTERS, M.D., Fremont

OBSTETRICS—GYNECOLOGY—PEDIATRICS

8:30 "Hazards from Improper Use of Certain Drugs Commonly Employed in Obstetric Practice"
NORMAN F. MILLER, M.D., Ann Arbor
Professor and Head of Department of Obstetrics and Gynecology, University of Michigan

8:50 "The Pathology and Treatment of Urethral Caruncles"
HAROLD D. DYKHUIZEN, M.D., Muskegon
Senior Urologist and Consultant in Urology of Hackley and Mercy Hospitals, Muskegon

9:10 "Pediatric Proctology"
EDWARD F. SLADEK, M.D., Traverse City
Past President, Michigan State Medical Society

9:30 "Hemorrhage"
C. PAUL HODGKINSON, M.D., Detroit
Gynecologist-Obstetrician-in-Chief, Henry Ford Hospital

9:50 "So You've Got a Diabetic"
WM. M. LEFEVRE, M.D., Muskegon
Councilor 11 District, Michigan State Medical Society

10:10 "The Early Diagnosis of Visual Impairment in Children"
CECIL W. LEPARD, M.D., Detroit
Ophthalmologist-in-Chief, Children's Hospital of Michigan; Associate Professor of Ophthalmology, Wayne State University College of Medicine

10:30 INTERMISSION TO VIEW EXHIBITS

11:15 to 12:45 COLOR TELEVISION PROGRAM, beamed to the Grand Ballroom, Sheraton-Cadillac Hotel through the co-operation of the staff of The Grace Hospital, Detroit and Smith, Kline and French Laboratories of Philadelphia

11:15 "Uterine Bleeding"
GEORGE S. FISHER, M.D., Detroit; E. S. HOFFMAN, M.D., Detroit

11:45 **"Diagnosis and Management of Acute Arterial Obstruction"**

JAMES B. BLODGETT, M.D., Detroit
Associate Attending Surgeon, Grace Hospital

12:15 **"Examination of the Patient with Acute Abdominal Pain"**

GORDON B. MYERS, M.D., Detroit
Professor of Medicine, Wayne State University College of Medicine

12:45 **End of Television Program**

JAMES B. BLODGETT, M.D.

GORDON B. MYERS, M.D.

SIXTH ASSEMBLY

Grand Ballroom, Sheraton-Cadillac Hotel
Chairman: RUSSELL F. FENTON, M.D., Detroit
Secretary: THEODORE I. BAUER, M.D., Lansing

GENERAL MEDICINE

P.M.

2:00 **"Preventive Medicine and Industry"**

O. TOD MALLERY, M.D., Ann Arbor
Medical Director, Employers Mutual Liability Insurance Company, Wausau, Wisconsin; formerly Director, Institute of Industrial Health, University of Michigan; Associate Professor of Internal Medicine, University of Michigan

O. TOD MALLERY, M.D.

2:20 **"Alcoholism and Emotional Immaturity"**

C. P. MEHAS, M.D., Birmingham
General Practitioner, Tuberculosis Consultant, Oakland County Health Department

C. P. MEHAS, M.D.

2:40 **FINAL INTERMISSION TO VIEW EXHIBITS**

3:15 **"Pharmaceutical Industry—Servant of Medicine"**
Speaker to be announced

3:45 **"Diabetic Legs"**

FREDERICK W. WILLIAMS M.D., Bronx, New York
President, American Diabetic Association; Associate Clinical Professor, New York Medical College; Vice Speaker, House of Delegates, New York State Medical Society

4:15 Speaker to be announced

4:45 **End of Sixth Assembly and the 1957 Michigan Clinical Institute**

FREDERICK W. WILLIAMS, M.D.

MSMS Ninety-first Annual Session - 1956

House of Delegates Proceedings

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X.	Resolutions and Motions:			
	1. Comprehensive Prepaid Medical Care Insurance Plan	1518	1533	substitute approved (see Res. 32)
	2. Michigan Medical Service Annual Report to MSMS House of Delegates	1518	1533	substitute approved XII.
	3. Honorary Membership to Dean Gordon H. Scott	1518	1532	approved
	4. Postgraduate Education of Other Healing Arts	1518	1531	deferred (see Res. 6)
	5. Practice of Psychotherapy is Practice of Medicine	1518	1533	approved
	6. MSMS Attitude re Other Healing Arts	1519	1531	deferred
	7. Council Minutes to all MSMS Delegates	1519	1531	disapproved
	8. Esteem of House of Delegates for the Late J. Joseph Herbert	1519	1535	approved XIII.
	9. ByLaws, Chapter 8, Section 10-g—Procedure in Case of Vacancy on The Council	1519	1530	approved as amended
	10. Report within Seven Days of House of Delegates Proceedings	1519	1532	disapproved (see Res. 39)
	11. Continuation of Councilor Conferences	1520	1532	approved
	12. Expansion of Medical School Facilities at Wayne State University	1520	1533	approved
	13. Establishment of Departments of General Practice in Medical Schools	1520	1532	approved
	14. Deferring Action re Discipline of Members (Mediation-Ethics-Grievance)	1520	1530	approved (see Res. 21)
	15. State and County Prerogatives in Discipline of Members	1520	1531	disapproved
	16. MSMS Approval of County Society Constitution and By-Laws Revisions	1520	1531	disapproved
	17. Equal Health Opportunities for All	1521	1532	approved
	18. ByLaws, Chapter 2, Section 2—Re Membership in County of Practice	1521	1531	disapproved
	19. Committee to Study Use of Word "Clinic"	1521	1532	approved
	20. Honorary Membership to the Late J. Joseph Herbert	1521		
	21. Approval of Mediation-Ethics-Grievance Committee's Recommendations	1521	1531	deferred for one year
	22. New MSMS Headquarters ($5.00 dues increase in lieu of present assessment)	1522	1535 1533	approved approved
	23. Regulation of Ambulance Operation	1522	1535	approved
	24. Appreciation of the Late Henry A. Luce, M.D.	1522	1533	approved
	25. Adequate Funds to Carry Out Civil Defense	1522	1532	as amended approved
	26. Permanent Advisory Committee on Fees	1522		as amended
	27. Constitution, Article X, Sections 1-2-3 — to make Vice Speaker a Voting Member of The Council and of its Executive Committee	1522	1532 (to 1957 House of Delegates)	Approved
	28. Urging Total Participation of M.D.'s in Michigan Medical Service (Heidenreich)	1523	1534	substitute approved (see Res. 30)
	29. ByLaws, Chapter 8, Section 10-j(13)—Changing name of a House of Delegates Reference Committee (National Defense and Disaster Planning)	1523	1531	approved
	30. Urging Total Participation of M.D.'s in Michigan Medical Service (Bowman)	1523	1534	substitute approved

		Introduction of Business	Reference Committee Report
31.	Annual Registration of M.D.'s	1523	1533; 1539 disapproved
32.	Blue Shield Plan for Diagnostic Out-patient Services	1529	1533 substitute approved
33.	Submission of House of Delegates Resolutions in Advance	1529	1539 disapproved
34.	Medical Classes at University of Michigan and Wayne State University to Send Representatives to House of Delegates Sessions	1529	1539 approved as amended
35.	Committee to Study Use of Excess Beds in Tuberculosis Sanatoria	1535	1540 approved
36.	MSMS Representatives on Committee Drafting Uniform Autopsy Code	1535	1539 approved as amended
37.	*Motion:* Information from AMA Delegates	1536	1539 tabled
38.	Appreciation to Harvey V. Higley, Veterans Administration Administrator	1538	1540 approved
39.	Plan for Expediting Work of House of Delegates	1535	1539 substitute approved (see Res. 10)
XI.	Reports of Standing Committees:		
1.	Postgraduate Medical Education	1524	1530
2.	Preventive Medicine and its Sub-Committees	1524	1530
3.	Public Relations and its Sub-Committees	1524	1530
4.	Ethics	1524	1530
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1.	Scientific Radio	1524	1530
2.	Advisory Committee to Woman's Auxiliary	1524	1530
3.	Advisory Committee to Michigan State Medical Assistants Society	1524	1530
4.	Committee to Study MSMS Financial Structure ($5.00 dues increase in lieu of present assessment)	1524	1534
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		Introduction of Business	Reference Committee Report
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6.	On Special Memberships ..... (a) Honorary Membership to J. Joseph Herbert and Dean Gordon H. Scott—1532.		1532
7.	On Legislation and Public Relations ..... (a) Resolution re Practice of Psychotherapy is Practice of Medicine—1533; (b) Resolution re Expansion of Medical School Facilities at Wayne State University—1533; (c) Resolution re Regulation of Ambulance Operation—1533; (d) Resolution re Adequate Funds to Carry Out Civil Defense —1533; (e) Resolution re Annual Registration of M.D.'s —1533 and 1539.		1533, 1539
8.	On Medical Service and Prepayment Insurance..... (a) Resolution re Michigan Medical Service Annual Report to MSMS House of Delegates—1533; (b) Resolution re Comprehensive Prepaid Medical Care Insurance Plans—1533 and (c) Resolution re Blue Shield Plan for Diagnostic Out-patient Services—1533; (d) and (e) Resolution Urging Total Participation of M.D.'s in Michigan Medical Service—1534.		1533, 1534
9.	On Miscellaneous Business..... (a) Committee to Study MSMS Financial Structure—1534; (b) Selection of Michigan's Foremost Family Physicians—1535; (c) Resolution Expressing Esteem of House of Delegates for the Late J. Joseph Herbert—1535; (d) Resolution of Appreciation of the Late H. A. Luce, M.D.—1535; (e) Resolution re New MSMS Headquarters—1535.		1534, 1535
10.	On Reports of The Council.....		1536
11.	On Hygiene and Public Health..... (a) Committee to Study Use of Excess Beds in Tuberculosis Sanatoria—1540.		1540
XIV.	Elections ..... (1) Councilor, First District—1540; (2) Councilor, Fourth District—1540; (3) Councilor, Fifth District—1540; (4) Councilor, Sixth District—1540; (5) Delegates to AMA—1541; (6) Alternate Delegates to AMA—1541; (7) President-Elect—1541; (8) Speaker of House of Delegates—1542; (9) Vice Speaker of House of Delegates—1542; (10) Councilor, Third District—1542.		1540, 1541, 1542

MSMS House of Delegates—1956

Summary of Proceedings

The Ninety-first Annual Session of the Michigan State Medical Society's House of Delegates was held in Detroit, September 24-25, 1956.

The House of Delegates:

1. Adopted with thanks the President's Address, the President-Elect's Address, the report of Delegates to the American Medical Association, the Annual Report of the President of Woman's Auxiliary to Michigan State Medical Society, and the Annual Report of the President of Michigan State Medical Assistants Society.

2. The Annual Reports of The Council (including the Annual Reports of Committees of The Council) were adopted as amended.

3. Adopted Annual Reports of all Standing Committees and of all Special Committees of the Society; also the report of the House of Delegates' Committee to Study MSMS Financial Structure.

4. Elected Ralph G. Cook, M.D., Kalamazoo, and J. H. Sherk, M.D., Midland (posthumously), as Michigan's Foremost Family Physicians for 1956.

5. Took action on proposed amendments to Constitution and By-Laws, as follows: (a) By-Laws, Chapter 8, Section 10-g—procedure in case of vacancy on Council—approved as amended; (b) By-Laws, Chapter 2, Section 2—re membership in county of practice—disapproved; (c) Constitution, Article X, Sections 1-2-3—to make Vice Speaker a voting member of The Council and of its Executive Committee—to 1957 House of Delegates; (d) By-Laws, Chapter 8, Section 10-j (13)—changing name of a House of Delegates Reference Committee (National Defense and Disaster Planning)—approved.

6. Adopted resolutions concerning: (a) Deferring Action re Discipline of Members; (b) Continuation of Councilor Conferences; (c) Establishment of Departments of General Practice in Medical Schools; (d) Committee to Study Use of Word "Clinic"; (e) Equal Health Opportunities for All; (f) Permanent Advisory Committee on Fees (as amended); (g) Practice of Psychiatry is Practice of Medicine; (h) Honorary Mem-

bership to J. Joseph Herbert and Dean Gordon H. Scott; (i) Expansion of Medical School Facilities at Wayne State University; (j) Regulation of Ambulance Operation approved and referred to Committee on Traffic Safety; (k) Adequate Funds to carry out Civil Defense (as amended); (l) Medical Classes at Medical Schools to send Representatives to House of Delegates Sessions (as amended); (m) MSMS representatives on Committee Drafting Uniform Autopsy Code (as amended); (n) Esteem of House of Delegates for J. Joseph Herbert; (o) Appreciation of Henry A. Luce, M.D.; (p) New MSMS Headquarters; (q) Appreciation to H. V. Higley, Veterans Administration Administrator; (r) Committee to Study excess beds in Tuberculosis Sanatoriums.

7. Adopted substitute resolutions concerning: (a) Michigan Medical Service Annual Report to MSMS House of Delegates; (b) Comprehensive Prepaid Medical Care Insurance Plans and Blue Shield Plans for Diagnostic Out-Patient Services; (c) Urging Total Participation of M.D.'s in Michigan Medical Service (two resolutions); (d) Plan for Expediting Work of House of Delegates.

8. Tabled Motion re Information from AMA Delegates.

9. Deferred Resolutions re: (a) Postgraduate Education of Other Healing Arts; (b) MSMS Attitude re Other Healing Arts; (c) Approval of Mediation-Ethics-Grievance Committee's Recomemndations.

10. Disapproved Resolutions concerning: (a) Council Minutes to all MSMS Delegates; (b) Annual Registration of M.D.'s; (c) Submission of House of Delegates Resolutions in Advance; (d) Report Within Seven Days of House of Delegates Proceedings; (e) State and County Prerogatives in Discipline of Members; (f) MSMS Approval of County Society Constitution and By-Laws Revisions.

11. Elected to Special Memberships:

(a) Thirty-one members to Life Membership: (Berrien County) Clarence Gillette, M.D.; (Genesee County) Henry Cook, M.D.; (Ionia County) J. W. C. Fleming, M.D.; (Kalamazoo County) U. Sherman Gregg, M.D.; (Marquette County) Celestin LeGolvan, M.D., and George M. Waldie, M.D.; (Muskegon County) Harry L. Clark, M.D., Marie Keilin, M.D., and Eugene S. Thornton, M.D.; (Oakland County) George L. Hagman, M.D., and John K. Ormond, M.D.; (Wayne County) Stilson R. Ashe, M.D., William N. Braley, M.D., Fritz W. Bramigk, M.D., Bruno B. Brunke, M.D., Peter H. Darpin, M.D., Henri L. Gratton, M.D., Sarkis K. Keshishian M.D., John C. Koch, M.D., Alfred D. LeFerte, M.D., Wm. W. MacGregor, M.D., Emil V. Mayer, M.D.; Wm. R. McClure, M.D., Carey P. McCord, M.D., Wm. E. Miller, M.D., Grover C. Penberthy, M.D., Lyman J. Pinney, M.D., Ralph W. Ridge, M.D., Paul C. Rhode, M.D., Jacob M. Sutherland, M.D. and Elmer L. Whitney, M.D.

(b) Nine members to Retired Membership: (Calhoun) A. D. Sharp, M.D.; (Saginaw County) Lloyd A. Campbell, M.D.; (Wayne County) Ladislaus Bogusz, M.D., Clyde H. Chase, M.D., James C. Danforth, Sr., M.D.; Frank MacKenzie, M.D., William D. Ryan, M.D., Clarence E. Weaver, M.D., and Wirt A. Dawson, M.D.

(c) Fifty-nine M.D.'s to Associate Membership: (Marquette-Alger County) Sara Schweinsberg, M.D.; (Muskegon County) Mary Ellen Hennessey, M.D.; (Washtenaw County) Malcolm A. Bagshaw, M.D., Joseph B. Boulos, M.D., Gerald L. Brody, M.D., Joseph H. Chandler, M.D., Norman E. Clarke, Jr., M.D., Mark A. Everett, M.D., Norman A. Fox, Jr., M.D., Robert L. Gillett, M.D., Glenn G. Golloway, M.D., Jack E. Goodwin, M.D., John T. Hayes, M.D., Erwin P. Hoffman, M.D., Clifford L. House, M.D., Edwin M. Hubbard, M.D., A. Hartwell Jewell, Jr, M.D., J. A. Arthur Lavigne, M.D., George E. Lewis, Jr., M.D., John D. Lynch, M.D., James W. Mackenzie, M.D., Henry E. Malcolm, M.D., Rolf F. Miller, M.D., Robert F. Muller, M.D., Paul Natvig, M.D., Rudolf E. Nobel, M.D., Leon D. Ostrander, Jr., M.D., Warren H. Pearse, M.D., Chrisostomo C. Santos, M.D., Harry J. Schmidt, M.D., Russell Scott, Jr., M.D., Irving Shapiro, M.D., Edwin M. Smith, M.D., Philip R. Steinmetz, M.D., John P. Stewart, M.D., George R. Thompson, M.D., Frederik S. Van Reesema, M.D., Peter D. Vreede, M.D., Donald J. Holmes, M.D., Prasana K. Pati, M.D., John B. Tisserand, M.D., William S. Wilson, M.D., and James A. Wood, M.D.; (Wayne County) Oscar L. Barland, M.D., Robert Borchak, M.D., Richard A. Bruehl, M.D., John P. Connolly, M.D., Douglas R. Coyne, M.D., Leonard Fox, M.D., Maurice J. Hauser, M.D., Loyal W. Jodar, M.D., Benjamin Mihay, M.D., John H. Schlemer, M.D., Fredrick L. Sperry, M.D., Bela J. Szappanyos, M.D., Jerome S. Weingarten, M.D., Frank A. Weiser, M.D., Joseph Weiss, M.D., and Charles R. Williams, M.D.

12. Elected the following officers:

(a) A. E. Schiller, M.D., Detroit, as Councilor of the 1st District (1961).

(b) H. J. Meier, M.D., Coldwater, as Councilor of the 3rd District (1961).

(c) Ralph W. Shook, M.D., Kalamazoo, as Councilor of the 4th District (1961).

(d) C. Allen Payne, M.D., Grand Rapids, as Councilor of the 5th District (1961).

(e) H. H. Hiscock, M.D., Flint, as Councilor of the 6th District (1961).

(f) W. D. Barrett, M.D., Detroit (1958); W. H. Huron, M.D., Iron Mountain (1958); and R. L. Novy, M.D., Detroit (1958), as Delegates to the American Medical Association.

(g) William Bromme, M.D., Detroit (1958); J. R. Rodger, M.D., Bellaire (1958); and G. W. Slagle, M.D., Battle Creek (1958), as Alternate Delegates to the American Medical Association.

(h) G. W. Slagle, M.D., Battle Creek, as President-Elect.

(i) K. H. Johnson, M.D., Lansing, as Speaker, House of Delegates.

(j) J. J. Lightbody, M.D., Detroit, as Vice Speaker, House of Delegates.

Michigan State Medical Society

Ninety-first Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION

September 24, 1956

The ninety-first annual session of the House of Delegates of the Michigan State Medical Society, held at the Sheraton-Cadillac Hotel, Detroit, Michigan, on September 24-25, 1956, convened at 10 a.m., J. E. Livesay, M.D., Speaker of the House, presiding.

I. RECORD OF ATTENDANCE

Office	*Officer*	*Meetings*				
		1st	*2nd*	*3rd*	*4th*	*5th*
Speaker	J. E. Livesay, M.D.	x	x	x	x	x
Vice-Speaker	K. H. Johnson, M.D.	x	x	x	x	x
Secretary	L. Fernald Foster, M.D.	x	x	x	x	x
County	*Delegate*					
1. Allegan	L. F. Brown, M.D.	x	x	x	x	x
2. Alpena-Alcona-Presque Isle	E. S. Parmenter, M.D.	x	x	x	x	x
3. Barry	A. B. Gwinn, M.D.	x	x	x	x	x
4. Bay-Arenac-Iosco	O. J. Johnson, M.D.	x	x	x	x	x
	D. A. Bowman, M.D.	x	x	x	–	x
5. Berrien	D. W. Thorup, M.D.	x	x	x	x	x
	N. J. Hershey, M.D.	x	x	x	x	x
6. Branch	H. J. Meier, M.D.	x	x	x	x	–
7. Calhoun	H. C. Hansen, M.D.	x	x	x	x	x
	J. W. Hubly, M.D.	x	x	x	x	x
8. Cass	S. L. Loupee, M.D.	x	x	x	x	x
9. Chippewa-Mackinac	W. F. Mertaugh, M.D.	x	x	x	x	x
10. Clinton	F. W. Smith, M.D.	x	x	x	x	x
11. Delta-Schoolcraft	J. H. Fyvie, M.D.	x	x	x	x	x
12. Dickinson-Iron	D. R. Smith, M.D.	x	x	x	x	x
13. Eaton	P. H. Engle, M.D.	x	x	x	x	x
14. Genesee	C. W. Colwell, M.D.	x	x	x	x	x
	C. K. Stroup, M.D.	x	x	x	x	x
	F. D. Johnson, M.D.	x	x	x	x	x
	G. E. Anthony, M.D.	x	x	x	x	x
	F. W. Baske, M.D.	x	x	x	x	x
15. Gogebic	D. C. Eisele, M.D.	Not represented				
16. Grand Traverse-Leelanau-Benzie	D. G. Pike, M.D.	x	x	x	x	x
17. Gratiot-Isabella-Clare	E. S. Oldham, M.D.	x	x	x	x	x
18. Hillsdale	A. W. Strom, M.D.	x	x	x	x	x
19. Houghton-Baraga-Keweenaw	P. S. Sloan, M.D.	x	x	x	x	x
20. Huron	C. W. Oakes, M.D.	x	x	x	x	x
21. Ingham	J. M. Wellman, M.D.	x	x	x	x	x
	H. W. Harris, M.D.	x	x	x	x	x
	F. L. Troost, M.D.	x	x	x	x	-
22. Ionia-Montcalm	R. E. Rice, M.D.	x	x	x	x	x
23. Jackson	W. A. Wickham, M.D.	x	x	x	x	x
	H. W. Porter, M.D.	x	x	x	x	x
24. Kalamazoo	W. A. Scott, M.D.	x	x	x	x	x
	S. E. Andrews, M.D.	x	x	x	x	x
	F. C. Ryan, M.D.	x	x	x	x	x
25. Kent	K. E. Fellows, M.D.	x	x	x	x	x
	W. J. Fuller, M.D.	x	x	x	x	x
	R. A. Rasmussen, M.D.	x	x	x	x	x
	A. V. Wenger, M.D.	x	x	x	x	x
	W. C. Beets, M.D.	x	x	x	x	x
	J. T. Boet, M.D.	x	x	x	x	x
	G. W. DeBoer, M.D.	x	x	x	x	x
26. Lapeer	D. J. O'Brien, M.D.	x	x	x	x	x
27. Lenawee	G. C. Wilson, M.D.	x	x	x	x	–
28. Livingston	H. C. Hill, M.D.	x	x	x	x	x
29. Luce	D. C. Adams, M.D.	–	x	x	x	–
30. Macomb	Sydney Scher, M.D.	x	x	x	x	x
31. Manistee	E. A. Oakes, M.D.	x	x	x	x	x
32. Marquette-Alger	A. S. Narotzky, M.D.	x	x	x	x	x
33. Mason	H. G. Bacon, Jr., M.D.	x	x	x	x	x
34. Mecosta-Osceola-Lake	Paul Ivkovich, M.D.	x	x	x	x	x
35. Menominee	J. R. Heidenreich, M.D.	x	x	x	x	x
36. Midland	M. J. Ittner, M.D.	x	x	x	x	x
37. Monroe	T. A. McDonald, M.D.	x	x	x	x	–
38. Muskegon	R. D. Risk, M.D.	x	x	x	x	x
	N. W. Scholle, M.D.	x	x	x	x	x
39. Newaygo	J. P. Klein, M.D.	x	x	x	x	x
40. North Central	E. H. Rodda, M.D.	x	x	x	x	x
41. Northern Michigan	J. R. Rodger, M.D.	x	x	x	x	x
42. Oakland	J. M. Markley, M.D.	x	x	–	x	x
	P. E. Sutton, M.D.	x	x	x	x	x
	H. A. Furlong, M.D.	x	x	x	x	–
	E. B. Cudney, M.D.	x	x	x	x	x
	E. W. Bauer, M.D.	x	–	x	x	x
	W. J. Zimmerman, M.D.	x	x	x	x	x
43. Oceana	W. G. Robinson, M.D.	Not represented				
44. Ontonagon	C. R. Lahti, M.D.	Not represented				
45. Ottawa	Otto Vander Velde, M.D.	x	x	x	x	x
46. Saginaw	J. P. Markey, M.D.	x	x	x	x	x
	A. C. Stander, M.D.	x	x	x	x	x
	F. J. Busch, M.D.	x	x	x	x	x
47. Sanilac	K. T. McGunegle, M.D.	x	x	x	x	x
48. Shiawassee	C. L. Weston, M.D.	x	x	x	x	x
49. St. Clair	J. F. Beer, M.D.	x	x	x	x	x
50. St. Joseph	S. A. Fiegel, M.D.	x	x	x	x	x
51. Tuscola	L. L. Savage, M.D.	x	x	x	x	x
52. Van Buren	F. J. Loomis, M.D.	x	x	x	x	x
53. Washtenaw	R. W. Teed, M.D.	x	x	x	x	x
	O. K. Engelke, M.D.	x	x	x	x	x
	P. S. Barker, M.D.	x	x	x	x	x
	H. F. Falls, M.D.	–	x	x	x	x
	G. H. Bauer, M.D.	x	x	x	x	x
54. Wayne	L. R. Leader, M.D.	x	x	x	x	x
	L. J. Bailey, M.D.	x	x	x	x	x
	R. R. Cooper, M.D.	x	x	–	x	x
	R. L. Novy, M.D.	x	x	x	–	x
	J. J. Lightbody, M.D.	x	x	x	x	x
	J. G. Molner, M.D.	x	x	x	x	x
	E. A. Osius, M.D.	x	x	x	x	x
	E. H. Fenton, M.D.	x	x	x	x	x
	C. I. Owen, M.D.	x	x	x	x	x
	W. S. Reveno, M.D.	x	x	x	x	x
	D. I. Sugar, M.D.	x	x	x	–	x
	W. W. Babcock, M.D.	x	x	x	x	x
	G. S. Bates, M.D.	x	x	x	x	x
	M. L. Lichter, M.D.	x	x	x	x	–
	C. W. Sellers, M.D.	x	x	x	x	x
	J. B. Blodgett, M.D.	x	x	x	x	x
	W. S. Carpenter, M.D.	x	x	x	x	x
	W. L. Brosius, M.D.	x	x	x	x	x
	M. R. Weed, M.D.	x	x	x	x	–
	E. G. M. Krieg, M.D.	x	x	x	x	x
	A. Hazen Price, M.D.	x	x	x	x	x
	R. F. Fenton, M.D.	x	x	x	x	x
	C. L. Candler, M.D.	x	x	x	x	x
	R. H. Pino, M.D.	x	x	x	x	x
	F. P. Rhoades, M.D.	x	x	x	x	x
	P. C. Gittins, M.D.	x	x	x	x	x
	C. K. Hasley, M.D.	x	x	x	x	x
	Louis Jaffe, M.D.	x	x	x	x	x
	A. D. Rudemann, Sr., M.D.	x	x	x	x	x
	E. C. Texter, M.D.	x	x	x	x	x
	H. F. Dibble, M.D.	x	x	x	x	x
	Saul Rosenzweig, M.D.	x	x	x	x	-
	R. V. Walker, M.D.	x	x	x	x	x
	A. E. Price, M.D.	x	x	x	x	–
	L. S. Fallis, M.D.	x	x	x	x	–
	L. A. Pratt, M.D.	x	x	–	–	x
	S. E. Gould, M.D.	x	x	–	x	–
	E. H. Lauppe, M.D.	x	x	x	x	x
	H. B. Fenech, M.D.	x	x	x	x	x
	J. E. Croushore, M.D.	x	x	x	x	x
	L. T. Henderson, M.D.	x	x	x	x	x
	J. G. Bielawski, M.D.	x	x	x	x	x
	J. E. Hauser, M.D.	x	x	x	x	x
	D. A. Young, M.D.	x	x	x	x	x
	J. A. Kasper, M.D.	x	x	x	–	x
	J. D. Fryfogle, M.D.	x	x	x	x	x
	Myer Teitelbaum, M.D.	x	–	x	x	–
	William Sherman, M.D.	x	x	x	x	x
	L. W. Korum, M.D.	x	x	x	x	x
	G. S. Fisher, M.D.	x	x	x	–	x
	H. C. Rees, M.D.	x	x	x	x	–
	E. C. Long, M.D.	x	x	x	x	x
55. Wexford-Missaukee	R. V. Daugharty, M.D.	x	x	x	x	x

IN MEMORIAM

Each year at this time we announce the names of former members of this House who have passed away. I will also announce the passing of eighty-nine members of the Michigan State Medical Society since we last met.

Former Delegates and Alternates were:

Delta County—J. J. Walch, M.D.
Ingham County—E. H. Faust, M.D.; H. W. Wiley, M.D.
Kent County—Torrance Reed, M.D.
Menominee County—A. R. Peterson, M.D.
Midland County—J. H. Sherk, M.D.
Monroe County—W. J. Gelhaus, M.D.
Oakland County—R. H. Baker, M.D.
Shiawassee County—J. S. Janci, M.D.
Washtenaw County—W. M. Brace, M.D.
Wayne County—C. D. Brooks, M.D.; William Hamilton, M.D.; C. E. Simpson, M.D., K. L. Swift, M.D.
J. Joseph Herbert, Legal Counsel

May we stand, please, in memory of these men.

II. PRESIDENT'S ADDRESS

By W. S. Jones, M.D.

I have a word of advice for you as I bring you my last message as President of your State Society: "If you don't want to work, don't let them give you this job of being President." The Council, its Executive Committee, and even the staff have kept my nose on a grindstone, my neck in a noose, and my feet on the road ever since Bob Baker placed this seemingly innocuous ribbon around my innocent neck.

But I won't say I haven't enjoyed it, because I have.

I figure that working for the Michigan State Medical Society is just working for myself, because the Michigan State Medical Society is me, and it's you, and it's every doctor you represent. Perhaps we forget that sometimes. In fact, I know we do, because I've had the good fortune to talk to, and with, a large number of the county medical societies of this State; and, frankly, what some of our members don't know about their state society would fill a book—maybe several books.

Seriously, we've got a big task before us in communication. We've got men working for us who are experts in the field of communication; but they can't make us communicate with each other and with the rest of our membership unless we want to carry the message.

There are so many messages, and so many people who should hear them! The policies of the House of Delegates and the decisions made by The Council are sound. They are invariably in the public interest.

But, so often our own membership is not as informed as it should be. I believe that the best way to inform them is by word of mouth. By such means we can give the whole story, and each listener has an opportunity to ask questions for clarification. I am not decrying the value of bulletins, the Secretary's Letter, the JOURNAL, or other means of informing our members, but I do see the importance of having a few people in every county society who will keep themselves informed, and who will make it their responsibility to see that all members of that county society are equally well posted.

These message carriers must be you, gentlemen, the members of this House of Delegates, and I hope that you will not fail in this service. It is a year-round responsibility. If for some reason you feel uninformed, or if there are additional facilities you feel should be made available to keep you informed, it is within your power as a body and as individuals to obtain them.

An informed membership can be a great public relations force, for by our members' actions and by their words in each of the communities in our state, our policies and programs are best advanced.

This is not said to decry the value of our formal public educational program. The use of radio, television, newspapers, medical forums, adult education, and conferences of various natures are necessary and vital to our task, but they cannot do the job alone. The message must go from you to our members, and from them to the public as well. Now, let's see what we have to talk about.

I could review the work done this past year, the progress made, the battles won; but as the newsmen say, "There's nothing so dead as yesterday's newspaper." In fact, they call their files of yesterday's newspapers a "morgue." So, I would prefer to talk about the problems facing us today.

Certainly, we are faced with the need of reviewing Blue Shield and Blue Cross and the effect that each is having upon the practice of medicine in the several communities of Michigan.

A tremendous amount of work has been done by MSMS committees during the past year in an attempt to unravel the knotty problems that are involved in working with these two eminently successful plans. I say "successful" because the public has accepted them. They have become part of the warp and woof of our medical-economic pattern as they cover 50 per cent of our patients today. But their very success places a responsibility on us to, first, understand these plans and appreciate their advantages and their weaknesses; second, not to expect from them answers to problems which are rightfully to be found in our own ethics and traditions; third, to support them by the most scrupulous adherence to the principles of fair play.

The doctor who expects these plans to provide him with an extraordinary income, who expects them to solve the problem of division of fees, and who takes advantage of the plans to increase his practice beyond his competence, is a menace to his fraternity. The converse is equally true. We can solve these problems—but we can do so only with patience, good will, and being reasonably unselfish.

Another problem is the legislative situation. The legislature has been kind to us for the past several years. But there are powerful forces in the legislature working against us and the principles we stand for. There are still other legislators who are our friends but whose patience is wearing thin because they are constantly being bombarded with requests for the solution to problems that rightfully should be solved outside the legislature, and which are not solved.

And then there are problems that need legislative action. To be quite specific: Certain unions, the chiropractors, the naturopaths and various other groups are powerful opponents, either singly or in their aggregate. The osteopathic problem is not one which the legislature should solve. We should solve it!

Problems such as the need for expansion of medical training opportunity, annual registration of M.D.'s, migratory labor, a state medical examiner system, and a single Healing Arts Practice Act are problems that need legislative action. I urge you not to close your eyes to the situation.

In this regard, you and I have responsibilities beyond that even of our members, because we are in the position of determining policies which affect the millions of people in Michigan. That is an obligation we accept with our office, and as citizens of this great state we cannot fail to discharge those obligations.

Certainly, the coming election provides us with an

opportunity to pick good men for public office who will help us solve these problems. I am told there are some fifty critical legislative contests out of the 160 that will be determined in this election. These contests are so balanced that hard work and strong support can tip the balance for good or bad. We can be that force—but it means recognizing duties other than those of healing the sick.

At the risk of incurring your displeasure, I feel the necessity of pointing to other problems facing us. I will not go into them deeply, but will just comment briefly

The veterans' care program and medical care of servicemen's dependents:—Both of these programs are in delicate balance and need your understanding. By the alert action of The Council and the courageous stand taken by the head of the Veterans Administration, Mr. H. V. Higley, the home town care plan for veterans was saved in Michigan. What seems to be a reasonable program has been outlined for the medical care of servicemen's dependents. But there will be "bugs" in that program too, and if it is to be handled properly it will need your wisdom and understanding.

The mental health problem:—Don't think you can dodge that one, nor that you can leave it to the psychiatrists to solve. We must recognize the primary interest of the psychiatrists in this field, but we also must recognize that they cannot and should not fight the battle alone.

Long ago the Michigan State Medical Society enunciated the policy which has been characterized as the "brains versus bricks" approach. Of late there are sympathetic ears in our state capitol to this idea, and it is up to us to provide them with reasonably, clearly-documented, unselfish advice.

Supply of medical personnel:—We haven't solved the problem of optimum supply of doctors of medicine, nor of medical associates, nor of placement of that medical personnel. We have gone far on this road, and we can be proud of our progress. I commend the M.D. placement program; but there are still occasions when doctors either have not made themselves available or were not available.

I point to the need of expanding the teaching personnel of Wayne State University College of Medicine, the extension of the medical associate training and recruitment campaign, and the establishment of a placement system for medical associates. Chronic disease hospitals and convalescent care homes will be an acute and major problem for the next few years until policies are developed for the financing, establishment and operation of such facilities.

I don't believe we want to be in the position of objecting futilely and fitfully to the policies that must and will be established. I think we want to be in the position of guiding the establishment of those policies.

I could go on and talk of the need for a private enterprise periodic health appraisal program, of social security, of the placement of optometrists, chiropodists and psychologists. I could review the problems of administration posed by the expanding use of radioactive materials. I could expand upon the dangers involved in the fabulous growth of lay-dominated health agencies.

Our problems are growing in severity and in number. We must grow as an organization if we expect to meet those problems with well-thought-out analyses and solutions. This means, without question, the expansion of our present headquarters office in Lansing or, more likely, the building of a new headquarters facility, specifically designed to meet our needs and permit our expansion. I recommend such a project to you. The start toward that end is long overdue.

In doing so, I express my deepest confidence that the medical profession can and will solve these problems. This body here, that has existed for over ninety years, will contribute to their solution.

Your Council is as devoted and sensible a group of skilled men as there exists in these United States. We have a staff that is imaginative and reliable.

The truth of these statements is accurately reflected in the two great losses we have suffered during the past year. I refer to the passing of Dr. Robert Baker and Mr. J. Joseph Herbert. In the former, we had a man who had served his profession far beyond the call of duty—a brilliant man who gave of his heart and his mind to medicine. Mr. Herbert has been equally valuable. His twelve years of service to medicine exemplified him as our friend and as the greatest of medical-legal counsels.

My earnest plea to you is that you have courage and patience, faith in your own leadership, and the wisdom to seek the advice of your medical and lay brothers, and then pass the word along.

Thank you for this privilege of speaking to you; and, in turn, I offer to each of you a personal invitation to attend the Officers' Night Banquet on Wednesday night. I'll see you there.

* * *

Dr. Jones' address was referred to the Reference Committee on Officers' Reports.

III. PRESIDENT-ELECT'S ADDRESS

By Arch Walls, M.D.

I wish to take this opportunity to express my appreciation for the great honor you have bestowed upon me. It is the highest position an individual is granted in his profession in the state society, and MSMS is one of the finest in the United States. I will assume the many duties and responsibilities with increased humility. I trust that I will be able, with your generous co-operation, to carry out these duties to the fullest extent and, by so doing, to keep the high standard set by my predecessors.

While addressing you today, it might be well to point out to you the responsibilities of a delegate. To understand fully and appreciate the importance of being a delegate to the Michigan State Medical Society House of Delegates, it is necessary to review the administrative setup of the state society.

The House of Delegates is the legislative and policy-making group of organized medicine. Its members, 135 in number, elected by the component county societies on the basis of one delegate for every fifty members or major fraction thereof, meet regularly once a year. Their policies and recommendations are implemented by The Council, which meets three times a year, and the Executive Committee, which meets once a month.

It is obviously apparent that this democratic plan gives the individual member of the Michigan State Medical Society his representation in the development of medical plans through his chosen delegate. There devolves, therefore, upon the delegate a responsibility of reflecting his constituents' views in the deliberation of the House of Delegates. To do this adequately, he must enter into discussions and lend his advice and counsel to the House of Delegates and its reference committees.

His responsibilities do not end there. He has not fulfilled his entire responsibility unless, when he returns home, he fully explains to his county society the deliberations and decisions of the House of Delegates and the reasons for such actions. Only by such a full and thorough report can the individual member of the Michigan State Medical Society be expected to react intelligently to any proposals propounded by his legislative body.

Your delegate is a most important person, and should be chosen only on the basis of his willingness to assume the full responsibilities of that assignment.

Progress of Medicine.—Modern medicine has made outstanding gains in the various scientific fields.

In immunization, we have seen great progress in the control of many diseases as new and better vaccines work toward the eradication of polio, smallpox, diphtheria and tetanus. These will continue to improve, and our armamentarium will give us new hope for great service in preventive medicine.

In research, great strides are being made toward the control of major neurologic disorders, in determining the relationship between viruses and cancer, in controlling infectious forms of arthritis, and even in discovering the cause of atherosclerosis.

In surgical procedures, we are doing things today, safely and routinely, that were almost undreamed of twenty years ago. The swift advance in anesthesia and in techniques of surgery are permitting our surgeons to work in areas that have heretofore defied their scalpel.

Big victories are behind and ahead of us; and although their stories have not yet been fully told, the public has taken for granted that we will continue to progress.

Yes, together with those whose science is related to medicine, we have made great strides in medical science. We will make even greater scientific progress, and the Michigan State Medical Society will continue to be a major force in bringing about those advancements.

Art of Medicine.—But we must do more than advance medicine as a science. We must also advance the art of medicine. We understand our healing work to be something more than that of a scientific mechanic working upon a mechanical body with mechanical equipment. We know the value of the "personal touch," of the human relationship between the doctor and his patient. We are constantly reminded by our medical scientists themselves of the importance of the emotional factor in the patients who entrust themselves to us.

These things are of tremendous import to our patients and to our profession, and yet it is in this area that we are making least progress. I invite this to your attention because, as a Society and as individual doctors, I believe we have a responsibility to do something about it, and I believe we can do something about it.

You will have before you recommendations for improvements in the handling of mediation, ethics and grievance problems. That is a forward step. I think we can go further. I think we can go behind the surface problem and, by education and moral suasion, remedy the condition that has caused these symptoms.

I believe we should call upon the great thinkers in the realm of the spirit to address us and write for our journals, just as we call upon the great researchers in the realm of science. God has endowed us with generous human consideration for the sick, and we must devise the ways and the means, the procedures and the time to give that consideration to our patients.

I urge our medical schools to do likewise. If they were to do so, their medical graduates would be better doctors even though it meant a partial loss of hours spent on more scientific subject matter.

Our Responsibility as Citizens.—The practice of medicine involves many things besides the treatment of the patient. It involves our place as a citizen of our country and our community. For every dollar we have spent for our education the community has contributed three, and the people rightly expect a return in addition to the competent medical care of the sick.

To give this additional service we must co-operate with others and we must have the co-operation of others. One segment of those we serve is represented by labor unions. No labor leader to my knowledge has ever come to the MSMS and offered either his help or the help of his union in solving the medical and health problems confronting the people. That is an error on their part.

If labor unions expect to improve the medical and health care of their members, they must co-operate with the medical profession; for no labor union can render medical care—only a physician can do that—and the conditions under which that medical care is rendered must be satisfactory to patient and physician alike or it will fail in its purpose.

But we must not make a similar error by refusing to welcome their help if it is offered. I have never known an offer of assistance from any source to be rejected. We have in the past indicated that our door was open.

I say again that the Michigan State Medical Society will give its most earnest consideration to any proffer of assistance by labor unions which they feel they can give in aiding the Medical Society and its members to render more and better medical and health care to the people of Michigan. I believe that that same open door policy must apply also to other professions—to osteopathy, psychology and chiropody, to mention only a few.

Public Relations.—Today's doctor of medicine and his society must do more than accept the aid of others. We can be proud that in Michigan our Society has adopted an attitude and a course of action to improve, by deed and by word, the welfare of the people. We will gain the good will of the people if we gain public understanding of that program, but to do so we must identify our activities and purposes with the public interest.

This is not solely a matter of publicity. It is certainly not a whitewash campaign, nor is it a political maneuver. Rather, it is a dedicated effort to carry out better a program already established by our Council and our Public Relations Committee.

In includes emergency call plans for twenty-four hour medical service; the fair adjustment of grievances; the orientation of our membership and of those who mold public opinion to the true purposes and activities of medical organization; the guarantee of medical care for all, and many other projects. These activities will win friends if we as individuals pledge our personal service both to the project and to its philosophy, rather than being satisfied with mere lip service.

A case in point: Your co-operation given during the emergency created by the discovery of a polio vaccine deserves commendation. You and your Society acted in the public interest, with no thought of personal gain. Now that the emergency created by a short supply of the vaccine is over, or nearly so, we can expect the immunization program to be relieved of governmental regulation and returned to the private practitioner. And I am sure that we can develop and support a program of polio immunization which will provide maximum benefits to the people.

I urge every county society and every doctor to read the MSMS brochure, "Winning Friends for Medicine," and carry out its recommendations where they are applicable.

Conclusion.—We should be proud to be members of the Michigan State Medical Society. It is progressive and able and, I firmly believe, the finest in these United States. We are blessed with an executive staff of unusual ability and devotion.

Dr. L. Fernald Foster, as our extremely capable Secretary, has sacrificed time and talent far beyond the call of duty or compensation, and is known from coast to coast for his ability in medical organization. He has been assisted by our Executive Secretary, Mr. William J. Burns, and our Public Relations Counsel, Mr. Hugh W. Brenneman, both of whom have received national honors and recognition for the work they have done for us and for the medical profession generally.

I commend these men and their devoted staff, and pledge myself, with your active help, to the carrying out of my responsibilities during the coming year.

* * *

Dr. Walls' address was referred to the Reference Committee on Officers' Reports.

IV. REPORTS OF THE COUNCIL

By D. Bruce Wiley, M.D., Chairman

The annual report of The Council is printed in your Handbook for Delegates, beginning on page 45. You have all had an opportunity to read and study it, and I shall not go over it at this time.

The Council wishes to present the following supplemental report as of September 23, 1956:

1. *Membership.*—On September 1, 1956, the membership of the Michigan State Medical Society totaled 6,157. This compares very favorably with the total of 5,899 at the same time last year.

2. *Finances.*

FINANCIAL REPORT FOR PERIOD ENDING AUGUST 31, 1956

Account	On Hand 1/1/56	Income to 9/1/56	Expenses to 9/1/56	Balance on Hand 9/1/56
General Fund	$ 77,593.98	$155,829.41	$113,822.68	$119,600.71
Annual Session		23,657.50	3,965.41	19,692.09
Michigan Clinical Institute		13,360.00	13,064.20	295.80
The Journal		60,412.93	54,259.35	6,153.58
Public Education	76,494.02	33,820.40	27,147.27	83,167.15
Public Service	281.28	18,871.13	8,247.82	10,904.59
Professional Relations	6,805.30	28,306.67	21,243.74	13,868.23
Public Education Reserve	30,000.00	26,958.75		56,958.75
Rheumatic Fever Control	22,704.24	10,000.00	17,161.17	15,543.07
Contingent Fund	37,267.34	16,175.25		53,442.59
Building Fund	13,788.46	10,783.50	8,277.68	16,294.28
Totals	$264,934.62	$398,175.54	$267,189.32	$395,920.84

3. *Michigan Medical Service.*—An up-to-date report on this corporation, including its finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 25, at 2 p.m., in Michigan Medical Service headquarters at 441 East Jefferson Avenue, Detroit. All MSMS delegates are members of Michigan Medical Service Corporation and are expected to attend this important annual meeting (which will be preceded by a 1 p.m. luncheon, compliments of Michigan Medical Service, also in its headquarters).

4. *Michigan's Foremost Family Physician of 1956.*—Selection of one of our Michigan general practitioners as nominee for the AMA Gold Medal Award is the privilege of the MSMS House of Delegates. According to the established procedure, the field of nominees has been narrowed by The Council to three, from which the House of Delegates elects one. The three nominees are:

Ralph Gilmore Cook, M.D., Kalamazoo
Henry J. Meyer, M.D., Saginaw
Paul Van Riper, M.D., Champion

This year The Council recommends that the House of Delegates present a second Michigan Foremost Family Physician Award posthumously to Joseph H. Sherk, M.D., of Midland, who died June 8, 1956. Had Dr. Sherk lived just a few months longer, his record of service to humanity would have made him eligible to favorable consideration for this award.

5. *List of Non-members.*—Pursuant to the House of Delegates' instructions of 1948, The Council (through Secretary L. Fernald Foster, M.D.) today submits a list of former members whose 1956 MSMS dues were not paid as of September 1, 1956. To insure accuracy, this list recently was submitted to and certified as correct by our component county and district medical society secretaries.

6. *MSMS Health and Accident Insurance Program.*—The report to September 14, 1956, supplied by the carrier (Provident Life and Accident Insurance Company of Chattanooga, Tennessee) is as follows:

Premiums collected	$574,412.95
Premiums earned	539,073.28
Claims paid	276,516.05
Reserves on claims reported and in process of payment	60,984.01
Reserves on claims incurred but unreported	17,140.48
Total claims paid and claim reserves	354,640.54
Loss ratio on earned and incurred basis	65.79 per cent

7. *Invitations to All New Practitioners.*—As instituted in 1954, all doctors of medicine who entered practice in Michigan since the last MSMS Annual Session recently were sent special invitations to attend the 1956 convention. In this group of over 400, nonmembers as well as members were included, with the thought that the Annual Session would indicate to nonmembers some of the many values of association with MSMS, recognized as one of the top three progressive state medical societies in the United States.

8. (a) *Death of J. Joseph Herbert.*—The Council announces with deep regret the passing of J. Joseph Herbert, who served as Legal Counsel of the Michigan State Medical Society for ten and one-half years. Mr. Herbert died in his sleep on July 28, shortly after returning from the three-day Mid-summer Session of The Council, in which he took his usual active part. The Michigan State Medical Society has lost an ardent and enthusiastic worker in Joe Herbert, a man much admired and loved by hundreds of our members.

(b) *Death of Immediate Past-President Robert H. Baker.*—Another sad announcement is the passing, on September 6, of beloved Bob Baker, who for years devoted generously of his time and energy to the betterment of the medical profession of this State and country.

Mr. Speaker, may we have your permission to pause in this report for a minute, as you may wish to request the House of Delegates to stand in memory of Dr. Baker and Mr. Herbert. (Silent standing tribute.)

9. *Poll on Social Security Question.*—The report on the social security poll, conducted among the component county and district societies of Michigan following an AMA request, is attached to this Council report as addenda. Twenty-two out of fifty-five societies did not reply. The reports of the balance were inconclusive. Some were opposed to compulsory social security for physicians; others favored social security as presently constituted, and some voted for a voluntary plan of social security for M.D.s. The issue, therefore, appears to be one which the House of Delegates may wish to decide.

10. *Medicare Program.*—The U. S. Congress recently adopted Public Law 569, known as the Medicare Act, to provide medical and surgical care not formerly available to servicemen's dependents who could not utilize existing military facilities. These dependents may now be treated, at government expense, by civilian physicians.

This 76 million dollar military dependents' medical care Act was discussed at an AMA-sponsored conference in Chicago on July 28-29 by state medical society representatives and Department of Defense personnel—the latter being most co-operative with the special Medical Advisory Committee.

The following key conclusions were reached at the Chicago conference:

(1) Fees will not be set on a national level but will be set by each state (or even county) medical society.

(2) The Department of Defense will accept any reasonable fee.

(3) Doctors of medicine must accept the established fee without an additional charge.

(4) Fee conflicts will be arbitrated by a local physicians' grievance committee.

(5) The government will not pay for elective procedures or for treatment of chronic illness.

(6) The program will be launched December 8.

The MSMS Council has appointed Michigan Medical Service as its negotiating and physical agent, with MMS Executive Vice President Jay C. Ketchum as the contact man.

Looking for the best plan of operation, the Special Advisory Committee has developed eight drafts of the regulations to implement the Medicare Act. As soon as Draft 8 of the implementing directions is approved by the Department of Defense, copies will be made available by the AMA to state societies, and MSMS in turn will immediately advise its fifty-five component societies. Some time thereafter a supplementing set of regulations will be issued jointly by the Departments of the Army, Navy, Air Force and Public Health Service to amplify and detail the operational implementation of DOD directive, and copies of these will be sent by the AMA to the states and by MSMS to its components.

AMA representatives will be continuing their contact with the appropriate government agencies as these developments occur; and, in like manner, Michigan Medical Service will continue its efforts in behalf of the medical profession of Michigan and the people whom our physicians serve.

11. *Governor's Study Commission on Prepaid Hospital Care Plans.*—During the past year a series of articles on Blue Cross and later Blue Shield appeared as feature articles in the *Detroit Free Press,* following the request of Michigan Hospital Service to the Insurance Commissioner of Michigan for a raise in premium rates, which raise met violent objections from various groups.

At the height of the publicity, the Governor appointed a Study Commission on Prepaid Hospital Care Plans, composed of representatives of almost all interested groups.

One of the Commission's first actions was to select as Study Director Dr. S. J. Axelrod of the Bureau of Public Health Economics, School of Public Health, University of Michigan. The MSMS Council objected to this appointment because "the publicly expressed opinion of the Bureau's Director (Nathan Sinai) and Assistant Director (S. J. Axelrod) over a number of years, concerning medical service, are at considerable variance with our nation's policy, and the views of the Michigan State Medical Society, and indicate certain preconceptions in this regard."

The Council felt that any such study should be undertaken by persons whose attitudes are completely objective and whose fields of competence extend to a greater variety of experience. The Society urged the Commission to have this survey made by a completely impartial group, to insure confidence and satisfaction among all segments of our citizens.

Some time after this protest, Dr. Axelrod resigned with the statement, as reported by the press: "The research program which was developed for the Commission requires the wholehearted co-operation on the part of the interested parties. It is quite clear that such co-operation will not be forthcoming, and under these conditions I feel that an effective research program cannot be carried out."

The resulting publicity pointed to the Michigan State Medical Society as objecting to the proposed study. However, this was not the case nor factual. The Council informed the Governor's Study Commission that MSMS favors an unbiased, authoritative, complete study of prepaid hospital care plans and of the costs of hospital care in Michigan generally, and that this has been the position of MSMS since the beginning of the work of the Governor's Study Commission, and it has not deviated from that position.

The Council's letter stated further that Dr. Axelrod's resignation removes the Society's concern that the proposed study would be placed in jeopardy. The Council's communication offered the Commission the Society's full co-operation and help in its work. (However, the Michigan State Medical Society fails to understand how unwarranted attacks in the press or elsewhere can aid such an official body in rendering assistance either to the public or the health groups, and the Commission should frown on such activity.)

Only the best equipped and most qualified (and completely impartial group or persons) should be called upon to undertake such an important study.

12. *Future Expansion of the Michigan State Medical Society.*—The present MSMS headquarters at 606 Townsend presently are adequate—but barely so. Future expansion will necessitate a larger and better functioning executive office. Such an MSMS building must be conducive to maximum business efficiency and be worthy of the Michigan State Medical Society, a headquarters of which the Michigan medical profession can well be proud! With this in mind, The Council has appointed a committee to investigate Lansing real estate for the purpose of purchasing an adequate site for MSMS, for future necessary expansion.

13. *Liaison Committee with Michigan Hospital Service.*—This Committee was reactivated during the past year at the specific request of Michigan Hospital Service made through personal invitation of its President, Mr. John W. Paynter. The personnel of this Committee are: W. S. Reveno, M.D., Detroit, Chairman; E. C. Baumgarten, M.D., Detroit; O. O. Beck, M.D., Birmingham; William Bromme, M.D., Detroit; C. W. Colwell, M.D., Flint; William LeFevre, M.D., Muskegon; J. D. Miller, M.D., Grand Rapids; R. L. Novy, M.D., Detroit; R. W. Shook, M.D., Kalamazoo; D. R. Smith, M.D., Iron Mountain; L. Fernald Foster, M.D., Bay City, Secretary.

This Committee will be advisory to Michigan Hospital Service in connection with any problems of a medical or professional character.

14. *M.D. Placement.*—The Michigan State Medical Society continued to work in co-operation with the Michigan Health Council in the M.D. Placement program. During the year seventy-seven placements were made, with thirty-two of them considered direct placements and forty-five indirect. Since the program began three years ago, 214 doctors have been placed. A total number of 150 Michigan communities are now listed with the Placement Service. There are 435 general practitioners and 255 specialists registered with the Service and seeking locations to practice.

As a new feature of the program, Michigan-born medical students who are graduated from out-of-state medical schools are contacted and urged to return to their home State to practice. This activity is meeting with some success.

15. *Matter Referred to the Council by the 1955 House of Delegates.*—The 1955 resolution re division of fees, Michigan Medical Service: The following report, adopted by the MSMS Study Committee on Fee Schedules for Michigan Medical Service, and approved by The Council, is respectfully submitted to the MSMS House of Delegates:

"WHEREAS, this Committee has given consideration to various programs or procedures for the accomplishment of the objectives of the resolution of the House of Delegates adopted September 26, 1955, re Division of Fees, and

"WHEREAS, this Committee has been charged with responsibility thereby for 'due consideration' of 'ethical, legal and administrative and other phases involved,' and *has given* due consideration thereto; therefore, be it

"RESOLVED: That the Committee reports to The Council as follows:

"(1) The Committee finds it impossible to determine a method of division of its scheduled fees for physicians by Michigan Medical Service as requested, which would be ethical, legal, and administratively feasible, and conform to opinions of the Judicial Council of the American Medical Association on the subject;

"(2) However, the Committee recommends that The Council request Michigan Medical Service to consider the inclusion in its subscribers' certificates of a benefit for the services of assistants in certain defined cases, and payment for such services directly to the asssitant."

16. *Annual Reports of Committees of the Council.* —Six additional reports have been submitted by Council committees since July 21 and are presented herewith as addenda for consideration of the reference committee. This will save reading them *in toto* to the entire House. These reports are from the following Committees: (a) Healing Arts Study Committee; (b) Mental Health Committee's Resolution re Psychotherapy; (c) Supplemental Report of Committee on Closed Panel Practice; (d) Supplemental Report of Committee on Michigan Medical Service; (e) Supplemental Report of Special Liaison Committee with Michigan Social Welfare Department, and (f) Committee on Rural Medical Service.

Mr. Speaker, if you or any member of the House of Delegates wishes these reports read word for word at this time, will you please instruct me?

THE SPEAKER: That would be a lot of reading. I hear no objections to your omitting that, Dr. Wiley.

Recommendations

We respectfully invite to your attention the nine recommendations in the original Annual Report of The Council, printed in the Handbook on page 81. They read as follows:

(1) That the 1 per cent collection credit now granted to county medical societies be eliminated, inasmuch as all membership billing will be performed by the Michigan State Medical Society, and will relieve component society secretaries of this detail work.

(2) That The Council be authorized to send MSMS representatives to Washington, D. C., in 1957 on the occasion of the Annual Michigan Day.

(3) That contributions to the Beaumont Memorial Restoration Fund—by every individual MSMS member —be urgently recommended by the 1956 House of Delegates, and that a special letter campaign be conducted. Thus, every MSMS member will be invited to contribute with pride to the Beaumont Memorial—which will represent for generations the best type of public relations for the entire medical profession in this State.

Further, that the following recommendation of the Beaumont Memorial Committee be given serious and favorable consideration by the House of Delegates: Recognizing that sustained effort is vital, a Beaumont Memorial Foundation be created immediately to further the purposes and continuing needs of the Beaumont Shrine at Mackinac Island, that every MSMS member be notified he is not only eligible to join at an annual membership fee to be established, but that he is invited and urged to join.

(4) That the House of Delegates instruct The Council whether or not the Uniform Fee Schedule for Governmental Agencies should be restudied and revised before necessary reprinting.

(5) That the recommendation of the Committee on Mediation, Ethics and Grievance be given serious consideration at this session by the House of Delegates. (These include proposed Bylaws changes in Chapters 6, 7 and 10). See Annual Report of this Committee for background and explanation showing need for these Bylaws amendments.

(6) That medical men become increasingly active in civic affairs, assuming the opportunities and obligations of their standing as leading citizens, to the end that public opinion generally is continued favorable to a maintenance of the present high standards of public health and medical education and service. This best is accomplished on the local level through active membership by doctors of medicine in chambers of commerce, health councils, and other reputable community and civic organizations.

(7) That members of the MSMS House of Delegates, as the natural leaders in their medical areas, express pride before their confreres in the excellent MSMS health and accident insurance program (Provident Life and Accident Insurance Company) so that during the ensuing Society year a substantial majority of members is enrolled in this protective device.

(8) That the following amendments to the Constitution and Bylaws be considered by the 1956 House of Delegates:

(a) Amend the Constitution in Article X, Section 3, so that the Vice Speaker of the House of Delegates is made a member of The Council and of its Executive Committee, with power to vote. (Also amend the Bylaws, Chapter 11, Section 10.)

(b) Amend the Bylaws in Chapter 8, Section 10-d to specify that AMA delegates and alternate delegates shall take office on January 1 following their election in September.

(c) Amend the Bylaws (Chapter 11, Section 4) so that all county medical societies in a councilor district first shall be contacted for approval of proposed appointment of a Councilor by the President, in case of resignation of a Councilor.

(9) That the House of Delegates eliminate the present assessment and authorize in lieu thereof an increase in dues adequate for the maintenance of our modern Society program and to insure reserves necessary to meet a major emergency.

In this Supplemental Report, The Council wishes to strengthen its recommendation No. 9—the need for building a needed surplus through a *permanent* dues increase. Not only must we consider expansion of MSMS services and the need for an adequate building, but reserves are required to meet a major emergency which may strike the medical profession "sooner than you think." To refresh your memories: When the Truman Socialized Medicine Plan hit us in 1948, we were fortunate to have reserves on hand of some $100,000, all of which and more were needed to fight and win that major battle. As of September 1, 1956 our public relations reserves are only $56,958.75. The Council judges this sum to be totally inadequate in the face of a major threat, and recommends that no less than $400,000 be set aside as a surplus (a) for the MSMS building, and (b) for emergency purposes. "Plan and work today for tomorrow" is advice good not only for the individual physician but for his medical organization as well.

The Council respectfully submits two additional recommendations:

(10) That the House of Delegates give favorable consideration to the following proposal: Since the work of the Michigan State Board of Registration in Medicine is much more time-consuming than heretofore, and is daily increasing in importance, the Michigan State Medical Society respectfully requests the Michigan legislature to make the office of Executive Secretary of the Michigan State Board of Registration in Medicine a full-time position; and that said Secretary be paid a salary commensurate with the importance and volume of his work.

(11) That in connection with the important subject of practice of psychotherapy, action similar to that taken by the Washtenaw County Medical Society (see addenda) be favorably considered by the House of Delegates, and further that the Michigan State Board

of Registration in Medicine be requested to institute proceedings or a test case against such violations of the Michigan Medical Practice Act.

Finally, The Council again asks the House of Delegates the question posed in its printed Annual Report (see page 55 of Report): Shall MSMS favor or be opposed to annual registration of doctors of medicine?

This report is respectfully submitted by The Council of the Michigan State Medical Society.

* * *

The Annual Report of The Council and all addenda were referred to the Reference Committee on Reports of The Council.

V. REPORT OF DELEGATES TO AMA

By W. A. Hyland, M.D.

It is customary to read our report. This year it is printed in the Handbook on pages 84 to 94 inclusive, so we will not go into that.

I would like to take a few moments to discuss the AMA with you, and also following that I would like to show a movie of the progress of the AMA and what it is doing for you.

This movie was prepared by the AMA Public Relations committee, to be sent out to all county societies in the country. This is the first time it will be shown, and it is in deference to the Public Relations Committee of the Michigan State Medical Society, which is so highly regarded by the American Medical Association; in fact, they make no bones about saying it is the top Public Relations Committee in the country.

I would like to say a few other things about the American Medical Association. The American Medical Association is a unique organization. It is a focal point for the world-wide exchange of scientific ideas. It is a protector of the nation's health. It is a tireless campaigner for a better America. But most of all, the American Medical Association is the doctors of America—145,000 medical men banded together to accomplish common goals.

As a dues-paying member of his county and state society and of the American Medical Association, each doctor has a voice in the American Medical Association's far-reaching activities. He contributes to a never-ceasing effort to improve the practice of medicine throughout the nation.

Occasionally, one hears among the profession the criticism that the AMA is a giant bureaucratic corporation with dictatorial powers; that all decisions affecting the state and county units, and thereby the individual doctor, are made within a tight little group who keeps that power and control unto themselves; that it has developed into a gigantic political lobby and collects excessive dues from its members, from which somebody within benefits.

This is a near-verbatim statement taken from a conversation between two doctors who evidently do not belong to the AMA but enjoy the protection and advantages it offers to all physicians, just as the unvaccinated child enjoys protection against small pox because so many people are vaccinated that an epidemic cannot occur. Both the medical opponents of the AMA and the lay opponents of vaccination are either unwilling or incapable, because of prejudice, to approach the matter with an open mind and assess all of the facts.

It is true the AMA is a mighty and powerful organization. If it were not, it would be of little value to the profession and equally valueless in protecting the public welfare. I could not begin even to mention all of the important functions of the AMA and how they are related to the profession and the public welfare, but two or three examples might be worth mentioning.

As a policy-making organization, the AMA has wielded a powerful influence in the field of medical education. In conjunction with the Association of American Medical College's inspection and rating, some 350 medical schools giving M.D. degrees were classified. Within a few years the number had decreased to one-third by eliminating the diploma mills and the very substandard school that either could not get students or whose graduates could not attain recognition by state licensing boards.

At the present time there are eighty-one recognized ("A" rating) medical schools, all giving high standard courses. It is true some of these substandard schools have been replaced by cultist schools over which the AMA has no control, but they cannot give an M.D. degree.

After graduation the AMA directs, through the state and county units, the ethical and moral conduct of its members in their relationship with each other and with the public. Without a powerful central organization there could be no assurance of uniformity of such codes of ethics. While most doctors need little disciplining, we do all need to know the rules, and there are a few "moths in our midst" to damage the whole fabric if they are not kept under control.

Day in and day out, nine standing councils, six standing committees—plus special departments and bureaus—work tirelessly at AMA headquarters to benefit both physicians and their patients.

The work of just one Council—the Council of Medical Education and Hospitals—has been credited with raising (as previously mentioned) the standards of medical education in the United States to the point where it is now the best in the world.

Activities of another representative Council—the Council on Pharmacy and Chemistry—are invaluable to each doctor-member of the AMA.

No one physician or group of physicians could possibly keep informed on relative merits of the hundreds of drugs put on the market annually by pharmaceutical companies. Backed by the total membership of the American Medical Association, the Council on Pharmacy and Chemistry does this job for each individual doctor.

The Council reports on the status of medicine, directs research and protects the profession and the general public against quackery, fraud, undesirable secrecy and objectionable advertising in connection with proprietary medicine.

In addition to directing such continuing activities, the American Medical Association's House of Delegates, through its Board of Trustees, meets other challenges as they arise.

An important function of the AMA is to keep a sharp and watchful eye on national legislation that might affect the profession and the public. Every bill that could effect the public health is carefully scrutinized, whether it has direct implications or not, and weekly (or oftener) reported to the state associations. Course of action to take in case of undesirable legislation is outlined, and concerted effort is the result. Through the efficient functioning of the AMA up to this time, the line has been held and we have been spared what might have been disaster.

When government-controlled medicine threatened, the profession united to educate the public on advantages of the voluntary system.

Through the organization of the American Medical Education Foundation the AMA has undertaken the deficit financing of the medical school which amounts to 10 million dollars this year. Out of their income (dues) the AMA has been contributing $500,000 a year. This does not sound like a waste of money. The profession is asked to contribute 2 million dollars.

It is my feeling that the AMA operates as democratically as a large central organization of its kind can. All important decisions are made by the House of Delegates by rank-and-file doctors representing each state. They are not "yes" men, and I have witnessed them thunder down resolutions or committee recommendations not to their liking.

I am very much opposed to regimentation, but I am just as strongly in favor of good organization; and, with all of its faults, I think the AMA falls in the latter category.

During its more than 100 years of existence the American Medical Association has dedicated itself to the betterment of medicine. In years to come, the American Medical Association will continue to function as its members dictate, to protect public health and to serve where service is needed.

I would like to read to you an editorial in a western newspaper, entitled, "Doctors' Ethics":

"A move is under way to shorten, and sharpen, the official Code of Ethics that guides the American Medical Association.

"Condensed from a sizable and admittedly verbose booklet, a concise statement of one page has been prepared for the Association's approval at its Seattle convention next December.

"Its very first declaration, in effect, defines the whole:

" 'The prime objective of the medical profession is to render service to humanity.'

"This sentence embraces the ideals and purposes of medicine since the time of Hippocrates and Galen.

"It is often valuable for doctors, no less than lawyers and clergymen, to have professional manifestos giving in detail their rules of conduct.

"Still more valuable is a moral atmosphere created silently and unobtrusively and, in America particularly, permeating the profession with a sense of dedication to the welfare of humanity.

"It can be said that no other profession has so cheerfully accepted the arduous toil, interminable hours and delayed economic benefits that doctors take as a matter of course.

"This can be expressed as a policy in a formal Code of Ethics, but it becomes a daily fact and practice only when practitioners adopt it as a natural viewpoint and manner of life implicit in our mission.

"We doctors have done that, to our honor and benefit."

Another thing the American Medical Association is concerned about and cannot do too much about as an organization because we feel we are not the ones to start it, is a study of income tax reduction. This is quite uppermost in the minds of the Board of Trustees, but they feel the doctors are not the ones to initiate this. However, they would like all of you as individuals to contact your legislators in Washington, urging them to have a study committee and to continue with the idea of reducing income taxes somewhat.

It is the feeling that at least 8½ billion dollars in taxes could be reduced with a little more care in Washington. The AMA is very much concerned about that.

The American Medical Association has two or three men in line for President: Gunnar Gundersen, Chairman of the Board of Trustees; Lois Orr, and Fritz Nassey, the Speaker and Vice Speaker. I think Dr. Orr and Dr. Gundersen will be up for election next year. Dr. Gundersen is from Wisconsin. our next door neighbor. Dr. Orr is a very good friend of all of us, and it will be interesting to see how they work it out.

I want particularly to thank all the members of the House of Delegates Committee—Drs. Barrett, DeTar, Huron, Novy, Penberthy, Owen, and so on, for all their loyal support, and the officers and public relations and legal counsel who have been of so much help to us.

If you will bear with me for a few minutes, I would like to have you review this motion picture with me and see what you think about it. You will probably gain something from it. I did.

The AMA Delegates' report was referred to the Reference Committee on Officers' Reports.

VI. REPORT OF WOMAN'S AUXILIARY TO MSMS

By Mrs. Rita McGregor, President

The Woman's Auxiliary to the Michigan State Medical Society this year holds its thirtieth annual meeting, a time when reports to be given will note the outstanding progress made by the Auxiliary during the past year. Michigan has had a good year—a stimulating and enlightening year—and, above all, one of excellent co-operation and combined efforts.

The list of our accomplishments is a long one. Each auxiliary has in some way done outstanding work and has contributed greatly to the projects of the state and national auxiliary. It is regrettable that each cannot be cited separately, but I would like to mention a few of the highlights.

Forty-seven organized auxiliaries, with Northern Michigan reorganizing this year, brings our membership to 3,063, with 261 new members. We are not as yet 100 per cent in membership, but we are progressing closer to that goal.

The sum of $3,200 was contributed to the American Medical Education Foundation, an increase of over 23 per cent, and better than $1.14 average per member—good evidence that the tireless efforts of our Chairman, Mrs. Victor Zerbi, have paid off. In addition, Michigan was among the top ten states in the eighty Dimes Campaign, with a contribution of $665.50.

Today's Health.—Subscriptions reached 88 per cent of our State quota (with 2,453 11/12 credits), an increase of 13 per cent. Fourteen auxiliaries reached 100 per cent or better; and Mason County, with a membership of nine, reached the almost unbelievable heights of 1,922 per cent—receiving second prize nationally in the 1955-1956 subscription contest. Michigan also was honored at the Second Annual *Today's Health* Breakfast held in Chicago during the convention in June.

Nurse recruitment takes top billing with all our auxiliaries, each participating in some way in this project. $11,349.73 was spent for recruitment activities, with $486.08 for Future Nurse Clubs, $3,538.65 for loans, and $7,325 for scholarships. This was an increase of 28 per cent, or an increase of over $2,500 over last year.

Many auxiliaries have shown interest in the allied fields as well. 3,465 students from eighty-seven schools, scattered over forty counties, participated in the Annual Tuberculosis Speaking Contest, a project sponsored jointly by the Michigan Tuberculosis Association and the Woman's Auxiliary. One hundred sixty talks were submitted for State judging. Students spoke to school and community audiences, totaling about 13,115, with forty local radio programs arranged by schools or local county auxiliaries, an excellent example of good public relations.

Each auxiliary is definitely aware of the importance of public relations, and contributes effectively. It would be ideal if each project could be mentioned, but the list is a long one—with assistance given at health days and fairs, to health councils, to schools on various phases of a health program, to hospitals and hospital auxiliaries, to sanatoria, to mention only a few.

A survey of the various volunteer services (in addition to those given in medical fields) such as Red Cross, Community Chest drives, PTA, Girl and Boy Scouts, cancer and polio drives, church activities, Junior League, AAUW, and so on, given by doctors' wives in their respective communities, revealed an average effort, by conservative estimate, of thirty-five hours per member per month. Again, evidence that doctors' wives more than carry their share of responsibility in their respective communities.

Emphasis was placed on a public relations meeting

to which guests from other organizations and/or the public at large were invited, with gratifying results. An outstanding program, held by the Woman's Auxiliary to the Saginaw County Medical Society, was an open meeting on "Doctor-Patient Relationship"—a panel discussion featuring an attorney as moderator. The medical society was represented by the president of the society, by a surgeon, and a general practitioner. Representing the general public were a news feature writer and a personnel manager. A lively and interesting discussion developed on such subjects as doctors' fees, willingness to make house calls, and so on.

Twelve auxiliaries have had joint meetings with allied groups, and two auxiliaries entertained the wives of senior medical students.

The auxiliaries responded quickly to the request of the MSMS to send letters and telegrams against bill HR 7225; and, although the bill was not defeated, it signified the interest and diligence of the members. The members have worked hard in the past on a "Get-Out-The-Vote" campaign, and this same enthusiasm again will be evidenced this fall.

Increased interest in civil defense; mental health and safety has been shown, many auxiliaries having programs devoted to these subjects.

There are many more accomplishments, but suffice it to say that Michigan has had a good year and has earned, by its outstanding activities, an enviable record among the state auxiliaries—a record of which we are all proud.

The Woman's Auxiliary is grateful for all the assistance, financial and otherwise, given to it by the Michigan State Medical Society, and in turn stands ready at all times to help further the aims, objectives and purpose of its parent organization.

At this time may I express my personal and sincere appreciation for the assistance and guidance given by the MSMS—by Dr. Jones, the MSMS President; by the Advisory Committee and Dr. Livesay as Chairman; by The Council; by Mr. Burns, Mr. Brenneman, Mr. Brewer, and the office staff. Such help has often made the going easier for me.

It has been a pleasure and an honor to serve as president of so fine an organization as the Woman's Auxiliary to the Michigan State Medical Society, and I am grateful for having had the opportunity.

* * *

The Woman's Auxiliary report was referred to the Reference Committee on Officers' Reports.

VII. REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS

By Miss Hallie Cummins, President

During the past year representatives of the Michigan State Medical Assistants Society attended the County Secretaries' Public Relations Conference, the Michigan Clinical Institute, a reception honoring the wives of the Michigan State Legislature by the Ingham County Woman's Auxiliary, the Michigan Health Council, and the Michigan Rural Health Conference.

Representatives, together with Dr. Ralph W. Shook, Vice Chairman of the Advisory Committee, attended the organizational meeting of the American Association of Medical Assistants in Kansas City. The valuable advice of Dr. Shook was of considerable assistance at this meeting.

Two Presidents' Conferences were held. Speakers from the State Medical Society and the Woman's Auxiliary, as well as the American Medical Association, presented subjects of much interest and importance to the officers and committee chairmen of the component societies who attend the conference.

We were privileged to hold an organizational meeting of the Upper Peninsula Medical Assistants during the annual meeting of the Upper Peninsula Medical Society, Again, speakers from the Michigan State Medical Society contributed their time and talents to help make this meeting a success. The courtesy and kindness shown us by the Upper Peninsula Medical Society and the Woman's Auxiliary is very much appreciated.

The number of our component societies still stands at sixteen, with one small Upper Peninsula society disbanding and replaced by the entire Upper Peninsula as a component society.

At this time our membership numbers 803—569 old members and 234 new. It is felt that there is considerable interest in our Society, since more and more inquiries regarding it are being received. We believe a great deal is to be gained by the medical assistant who affiliates with our Society.

We very much appreciate the honor and privilege of being able to hold our annual meeting in conjunction with the annual meeting of the Michigan State Medical Society. We are grateful for the space given us in the the JOURNAL, and for the programs which are printed and mailed to the doctors throughout the State each year.

Our meeting is being held at the Detroit-Leland Hotel on Wednesday and Thursday of this week. We would consider it an honor to have you attend any of our lectures which may be of interest to you.

* * *

The report of Michigan State Medical Assistants Society was referred to the Reference Committee on Officers' Reports.

VIII. SELECTION OF MICHIGAN'S FOREMOST FAMILY PHYSICIAN

By L. Fernald Foster, M.D., Secretary

An unusual situation presents itself this year on this occasion of the Foremost Family Physician Award. Due to the untimely passing of one of the men who had been nominated, this doctor's name had already been presented and the brochure on him completed. It is a most beautiful thing, a bound volume with all of the data and information about this man. He died in June after his Society had decided to present his name. I want to read to you the action of The Council bearing on this subject.

An excerpt from the minutes of The Council at the July 19-20-21 meeting relative to nominations for Michigan's Foremost Family Physician is as follows:

"That The Council recommends to the 1956 House of Delegates that two Michigan's Foremost Family Physician Awards be issued this year, one to J. H. Sherk, M.D., of Midland, posthumously, and one to a living doctor, said doctor to be chosen in the usual fashion."

The second motion was to the effect "That The Council submit the names of Paul Van Riper, M.D., Champion, from the Marquette-Alger County Medical Society; Ralph G. Cook, M.D., Kalamazoo; and Henry Meyer, M.D., Saginaw, to the House of Delegates as nominees for Michigan's Foremost Family Physician." (The portfolios on the three nominees were read.)

IX. FIFTY-YEAR AWARDS

THE SPEAKER: At this time we have a very pleasant duty to perform, and that is to honor the men who have been in practice fifty years. The Secretary has the certified list of these names, and as he calls their name will they please come to the front and receive their pin from President Jones.

The following doctors received their Fifty-Year Award from President Jones:

Ernest G. Bellinger, M.D., Lansing
Alexander W. Blain, M.D., Detroit
Phillip D. Bourland, M.D., Calumet
William DeKleine, M.D., Lansing
Lucius A. Farnham, M.D., Pontiac
Joshua Hanser, M.D., Detroit
Lemen L. Harrison, M.D., Niles
Wilfrid Haughey, M.D., Battle Creek
Edward V. Howlett, M.D., Pontiac
John W. Orr, M.D., Fenton
Melvin D. Roberts, M.D., Hancock
Frank J. Sladen, M.D., Detroit
Claude A. Smith, M.D., Dearborn
Clarence T. Starker, M.D., Pontiac
Thomas C. Starrs, M.D., Detroit
S. W. Thieme, M.D., Ravenna

(The meeting was recessed at 12:45 p.m.)

MONDAY AFTERNOON SESSION

September 24, 1956

The meeting reconvened at 2:15 p.m., J. E. Livesay, M.D., Speaker of the House, presiding.

X. RESOLUTIONS AND MOTIONS

X—1. COMPREHENSIVE PREPAID MEDICAL CARE INSURANCE PLAN

M. L. Lichter, M.D.:

"Whereas, it is the proper role of medicine to assume leadership in determining the type and form of prepaid medical care plans, and

"Whereas, a prepaid medical care plan ideally should embody within it a sense of mutual responsibility on the part of the physician and on the part of the patient, and

"Whereas, a medical care plan should preserve the traditional right of the patient to select the physician of his own choosing; therefore, be it

"RESOLVED: That the Michigan State Medical Society endorse the principle of a comprehensive prepaid medical care insurance plan to be developed with the Michigan Medical Service and implemented through a deductible and co-insurance contract; and be it further

"RESOLVED: That the Speaker of this House of Delegates be authorized to appoint forthwith a special committee to accomplish the following:

"(a) Meet with the representatives of Michigan Medical Service to develop details and mechanisms for implementing the enunciated principle.

"(b) Initiate, as a joint endeavor and in co-operation with Michigan Medical Service, necessary studies to ascertain what would best serve the public.

"(c) Prepare a complete report for presentation to the House of Delegates at its meeting in 1957 with the proviso that copies of this report shall be sent to each member of the House of Delegates by August 15, 1957."

This resolution was referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—2. MMS ANNUAL REPORT TO MSMS HOUSE OF DELEGATES

J. B. Blodgett, M.D.:

"Whereas, the Michigan State Medical Society established Michigan Medical Service with the intent of providing medical services on a voluntary basis through a prepayment plan, and

"Whereas, the expansion of Michigan Medical Service has become a significant factor in the practice of medicine in the State of Michigan, and

"Whereas, there is no direct liaison between Michigan Medical Service and the House of Delegates of the Michigan State Medical Society, which is the broad base representative of the practicing profession in Michigan; now be it.

"RESOLVED: That the Directors of Michigan Medical Service be requested to report annually to the House of Delegates of the Michigan State Medical Society on its programs, problems, and its philosophy."

This resolution was referred to the Reference Committee on Medical Service and Prepayment Plans.

X—3. HONORARY MEMBERSHIP TO DEAN GORDON H. SCOTT

E. A. Osius, M.D.:

"Whereas, Dr. Gordon H. Scott is Dean of the Wayne State University Medical School, the large majority of whose graduates practice in the State of Michigan, and

"Whereas, Dr. Scott has improved the quality of medical education by his participation in the educational activities of his County and State Societies and by his close and harmonious relationship with the profession, and

"Whereas, through his leadership and his untiring efforts he has expanded the facilities of the Wayne State Medical School and has promoted the development of a medical center in that area, and

"Whereas, one of the fundamental purposes of the Michigan State Medical Society is improving medical education and maintaining it at the highest possible level; therefore, be it

"RESOLVED: That in appreciation of his services to medical education in the State of Michigan, that Dr. Gordon H. Scott be elected an Honorary Member of the Michigan State Medical Society."

This resolution was referred to the Reference Committee on Special Memberships.

X—4. POSTGRADUATE EDUCATION OF OTHER HEALING ARTS

R. W. Teed, M.D.:

"Whereas, osteopaths in Michigan are currently furnishing approximately 25 per cent of the medical service for the people of Michigan, and

"Whereas, in certain communities in Michigan they furnish from 50 to 100 per cent of such service, and

"Whereas, it is incumbent on the medical profession to improve the quality of education and medical care given by these practitioners in the public interest; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society approve the majority findings of the AMA committee for the study of relations between osteopathy and medicine, to the effect that current education in colleges of osteopathy does not constitute the teaching of 'cultist' healing; and be it further

"RESOLVED: That the House declare its policy to be to encourage doctors of medicine to assist in osteopathic undergraduate and postgraduate medical educational programs; and be it further

"RESOLVED: That the Michigan State Medical Society and its component county societies be permitted to invite osteopaths to their scientific programs."

This was referred to the Reference Committee on Resolutions.

X—5. PRACTICE OF PSYCHOTHERAPY

P. S. Barker, M.D.:

"Whereas, the practice of psychotherapy as commonly understood has as its primary objective the diagnosis and relief of human ailments of mental origin, and

"Whereas, the interrelationships between ailments having a physical origin and those having a mental origin are extremely complex and can be diagnosed,

understood, and treated only by those having the training and experience of a duly licensed physician, and

"Whereas, the health and welfare of the people of Michigan and the County of Washtenaw would be jeopardized if such diagnosis and treatment were placed in the hands of other than licensed physicians, and

"Whereas, Opinion No. 2359 of Attorney General Thomas M. Kavanaugh seems to ignore the wording of the Medical Practice Act, which specifically includes ailments or complaints of mental origin as well as those of physical origin in its definition of medical practice, and

"Whereas, this opinion has been interpreted by certain psychologists and social workers as giving legal sanction to the diagnosis and treatment of mental disorder by those not licensed to practice medicine; therefore, be it

"RESOLVED: That the Michigan State Medical Society affirm its stand that the practice of psychotherapy constitutes the practice of medicine, and that Opinion No. 2359 of the Attorney General concerning the practice of psychotherapeutics is contrary to the public interest and should be revoked; and be it further

(See amendment of Reference Committee, page 203).

"RESOLVED: That copies of this resolution be sent to the Governor and Attorney General of the State of Michigan as well as to the officers of The Council of the Michigan State Medical Society to inform them of our stand on this matter."

This was referred to the Reference Committee on Legislation and Public Relations.

X—6. MSMS ATTITUDE RE OTHER HEALING ARTS

C. K. Stroup, M.D.:

"Whereas, some expression of reappraisal of our position with regard to osteopaths and their organization has been sought in some quarters; therefore, be it

"RESOLVED: That the Michigan State Medical Society maintain its present position in regard to osteopaths and osteopathy in accordance with the policy of the American Medical Association in recognizing them as substandard healers and unethical colleagues of doctors of medicine."

This was referred to the Reference Committee on Resolutions.

X—7. COUNCIL MINUTES TO ALL MSMS DELEGATES

F. D. Johnson, M.D.:

"Whereas, the House of Delegates is the governing body of the Michigan State Medical Society, and

"Whereas, The Council and its Executive Committee act for the Society and the House of Delegates throughout the year, and

"Whereas, the delegates meet once a year and review the work of The Council, and

"Whereas, the excerpts of Council activity as printed in the JOURNAL are fragmentary and incomplete, and

"Whereas, the work of the Society is too voluminous to permit accurate appraisal of all facets of our programs during one yearly meeting; therefore, be it

"RESOLVED: That the minutes of meetings of The Council and its Executive Committee be mailed to all delegates of the Michigan State Medical Society shortly after meetings are held."

This was referred to the Reference Committee on Resolutions.

X—8. ESTEEM OF HOUSE OF DELEGATES FOR THE LATE J. JOSEPH HERBERT

F. J. Busch, M.D.:

"Whereas, the medical profession of Michigan for the past twelve years has received the wise and able counsel of a distinguished lawyer and citizen, and

"Whereas, that valued service was rendered in a gracious, dignified and devoted manner by Mr. J. Joseph Herbert, Legal Counsel of the Michigan State Medical Society, who passed away on July 28, 1956, and

"Whereas, Mr. Herbert so lived that his memory will always remain a friendly, guiding light in our hearts and minds; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society and its several members forever keep in the annals of the medical profession of Michigan this expression of our highest esteem and admiration for Mr. Herbert; and be it further

"RESOLVED: That his widow, Mrs. Imogene Herbert, and his family be supplied with a copy of this resolution so that they will know that we join with them in honoring his memory."

This resolution was referred to the Reference Committee on Miscellaneous Business.

X—9 (ByLaws, Chap. 8—Sec. 10-g)—PROCEDURE IN CASE OF VACANCY ON COUNCIL

D. R. Smith, M.D.:

"Whereas, a vacancy on The Council may occur during the year other than at the time of the Annual Session, and

"Whereas, the Bylaws provide for this possibility only through the general power of a Presidential appointment to fill the vacancy; therefore, be it

"RESOLVED: That the following paragraph be incorporated into the Bylaws as the last paragraph of (g), Section 10, Chapter 8: 'If a vacancy occurs on The Council other than at the time of the Annual Session, all the component societies in the affected Councilor District shall be notified of the vacancy, and their recommendation as to a successor shall be sought. After receipt of these recommendations, the President of the MSMS shall appoint a successor to fill the unexpired term.' "—(Amended by Reference Committee)

This resolution was referred to the Reference Committee on Constitution and Bylaws.

X—10. REPORT WITHIN SEVEN DAYS OF HOUSE OF DELEGATE PROCEEDINGS

A. C. Stander, M.D.:

"Whereas, a summary of the proceedings of the House of Delegates is annually formulated, and

"Whereas, copies of resolutions are only made available to reference committees so that in debate on the floor of the House confusion may or has existed as to the wording of these resolutions, and

"Whereas, the Michigan State Medical Society has apparently adequate staff available; be it therefore

"RESOLVED: That a copy of all resolutions and other pertinent information of each previous meeting be available in mimeographed form at the beginning of the next meeting; and be it further

"RESOLVED: That a copy of the transactions of the House of Delegates be mailed to each delegate within a week after the annual House of Delegates meeting so he may have an early and accurate and complete report to present to his constituents."

This was referred to the Reference Committee on Resolutions.

X—11. CONTINUATION OF COUNCILOR CONFERENCES

F. C. Ryan, M.D.:

"Whereas, it is to the better interest of the Michigan State Medical Society for its delegates to be fully informed of the current business of the Society prior to the Annual Meeting of the House of Delegates, and

"Whereas, this purpose may be usefully served by informal meetings in the several Councilor Districts of its delegates and officers from the component societies, with the Councilor of the district and a representative from the Executive Committee of The Council; therefore, be it

"RESOLVED: That the House of Delegates authorize The Council of the Michigan State Medical Society to organize such meetings in the several Councilor Districts as may be appropriate and feasible prior to the Annual Meeting of the House of Delegates."

This was referred to the Reference Committee on Resolutions.

X—12. EXPANSION OF MEDICAL SCHOOL FACILITIES AT WAYNE STATE UNIVERSITY

W. S. Reveno, M.D.:

"Whereas, it is well recognized that a shortage of physicians' services still exists in Michigan, and

"Whereas, the number of qualified applicants for medical education exceeds the facilities for such education in our State, and

"Whereas, the physical equipment at Wayne State University College of Medicine reportedly is sufficient to allow the admission of fifty more first-year students each year, and

"Whereas, Wayne State University College of Medicine lacks sufficient funds to furnish teaching personnel necessary for this expansion of its enrollment; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society respectfully requests the Legislature of the State of Michigan to increase its appropriation to Wayne State University College of Medicine by a sufficient amount to allow the expansion."

This was referred to the Reference Committee on Legislation and Public Relations.

X—13. ESTABLISHMENT OF DEPARTMENTS OF GENERAL PRACTICE IN MEDICAL SCHOOLS

R. F. Fenton, M.D.:

"Whereas, there has been a declining proportion of medical graduates going into general practice, and

"Whereas, the medical student is not now exposed to the various requirements of general practice because of the fact that all his instructors are those limiting their practice to the various specialties, and

"Whereas, the modern generalist requires training in the art of medicine as well as the scientific approach, more knowledge of preventive medicine, physiotherapy, family counseling, medical and social economics and public relations in general, and

"Whereas, the House of Delegates of the American Medical Association has passed a resolution requesting that medical schools add a Department of General Practice to their curriculum; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society request the University of Michigan and the Wayne State Medical College to add a Department of General Practice to their curriculum."

This was referred to the Reference Committee on Resolutions.

X—14. DEFERRING ACTION RE DISCIPLINE OF MEMBERS

M. R. Weed, M.D.:

"Whereas, the Michigan State Medical Society has proposed amendments to its Bylaws which will radically alter the procedures of disciplining its members, and

"Whereas, these proposed Bylaw amendments will require changes in the present procedures of the county medical societies which vary considerably from each other because of difference in size and location; therefore, be it

"RESOLVED: That action on these proposed amendments be deferred so that each component county society may have an opportunity to recommend such changes as will reflect its experiences and fulfill its needs."

This was referred to the Reference Committee on Constitution and Bylaws.

X—15. STATE AND COUNTY PREROGATIVES RE DISCIPLINE OF MEMBERS

L. J. Bailey, M.D.:

"Whereas, at the 1956 session of the House of Delegates of the Michigan State Medical Society certain changes to Chapter 6 of the Bylaws, entitled 'Discipline of Members,' will be proposed, and

"Whereas, the constituent county societies should be allowed local autonomy in matters dealt with in these proposals, and

"Whereas, rules set down in detail may not apply equally well to all county societies, and

"Whereas, the ends of justice are fully met if procedures in disciplinary actions are fair; therefore, be it

"RESOLVED: That Section 1, Chapter 6 of the present Bylaws of the Michigan State Medical Society be retained, wherein it states, 'A component county society may expel, suspend or otherwise discipline any of its members in accordance with the provisions of its Constitution and Bylaws'; and be it further

"RESOLVED: That the county societies not be held to specific provisions in disciplinary actions except in matters pertaining to appeal, provided that the Bylaws of the component societies not be in contravention to those of the Michigan State Medical Society; and be it finally

"RESOLVED: That the Committee on Constitution and Bylaws be instructed, in its study of the proposed changes, to provide that the wording of such changes be sufficiently broad to permit of the implementation of acceptable details at the county level."

This was referred to the Reference Committee on Constitution and Bylaws.

X—16. MSMS APPROVAL OF COUNTY SOCIETY CONSTITUTION AND BYLAWS REVISIONS

L. J. Bailey, M.D.:

"Whereas, at the time of the chartering of component county societies the constitution and bylaws of such societies are approved by the chartering body, and

"Whereas, the constitution and bylaws of the county societies are subject to subsequent amendments and revision, and

"Whereas, approval of such amendments and revisions are not now provided for in the Constitution and Bylaws of the Michigan State Medical Society, and

"Whereas, such approval before final adoption would insure the continued adherence of the constituent societies to the provision of Section 1, Chapter 1 of the Bylaws of the Michigan State Medical Society, which states in part, 'The constitution and bylaws of the component county societies shall in no way be inconsistent with the Constitution and Bylaws of the Michigan State Medical Society'; therefore, be it

"RESOLVED: That the Committee on Constitution and Bylaws be requested to consider the attached draft which is an addition to the Bylaws requiring that all amendments to the constitution and bylaws of the component county societies be submitted for approval to The Council of the Michigan State Medical Society before final adoption."

This was referred to the Reference Committee on Constitution and Bylaws.

X—17. EQUAL HEALTH OPPORTUNITIES FOR ALL

L. R. LEADER, M.D.:

"Whereas, the health opportunities of the community are our basic concern, and

"Whereas, restriction or denial of health services and facilities because of race, creed, or color violates the spirit of our ethical code; therefore, be it

"RESOLVED: That the Michigan State Medical Society record itself as favoring equal health opportunities for all."

This was referred to the Reference Committee on Resolutions.

X—18. (ByLaws, Chapter 2, Section 2)—RE MEMBERSHIP IN COUNTY OF PRACTICE

SYDNEY SCHER, M.D.:

"Whereas, the Bylaws of the Michigan State Medical Society do not definitely state that a doctor of medicine is expected to become a member of the component society of the county in which his office is located, and

"Whereas, Chapter 2, Section 2 of the Bylaws of the Michigan State Medical Society, which provides for an exception, implies that a doctor of medicine is expected to hold his membership in the component society of the county in which his office is located, and

"Whereas, Chapter 2, Section 3 of the Bylaws of the Michigan State Medical Society states that each component county society shall have general direction of the affairs of the profession in the county and shall exert its influence for bettering the scientific, moral and material conditions of every doctor of medicine in the county, and

"Whereas, a component county society is unable to exert its influence to the fullest degree for the betterment of the practice of medicine in the county unless all eligible doctors of medicine practicing in the county are members, and

"Whereas, Chapter 2, Section 3 of the Bylaws of the Michigan State Medical Society urges each component county society to increase its membership until it embraces every eligible doctor of medicine in the county, and

"Whereas, Chapter 4 of the Bylaws of the Michigan State Medical Society provides for the transfer of membership from one component county society to another upon the change of location; therefore, be it

"RESOLVED: That Chapter 2, Section 2 of the Bylaws of the Michigan State Medical Society be changed to read as follows: 'A doctor of medicine must hold his active membership in the component society of the county in which his office is located. In the event the doctor's office is near a county line, he may be granted membership in a neighboring component county society on permission of The Council of the Michigan State Medical Society and on permission of the county society to which he would ordinarily belong under the provisions of this Section.' "

This was referred to the Reference Committee on Constitution and Bylaws.

X—19. COMMITTEE TO STUDY USE OF WORD "CLINIC"

P. S. SLOAN, M.D.:

"Whereas, during the last decade we have seen many changes in medical practice, such as the growth of groups, partnerships, clinics and medical centers, and

"Whereas, this growth and grouping of medical resources is natural and good, and in most instances results in better medical service for the public, and

"Whereas, the word 'clinic' implies resources and facilities not usually found in a private physician's office, and

"Whereas, there are rapidly becoming too many one- and two-physician clinics, which are unethical, misleading, false advertising; therefore, be it

"RESOLVED: That this House of Delegates of the Michigan State Medical Society request The Council to appoint a committee to study this situation and make recommendations to the House of Delegates for proper action."

This was referred to the Reference Committee on Resolutions.

X—20. HONORARY MEMBERSHIP TO THE LATE J. JOSEPH HERBERT

J. H. FYVIE, M.D.:

"Whereas, Mr. J. Joseph Herbert has been an honorary member of the Delta-Schoolcraft Medical Society for several years, and

"Whereas, Mr. Herbert was officially nominated by the Delta-Schoolcraft County Medical Society for honorary membership in the Michigan State Medical Society because of his long, devoted and able service to the medical profession, and

"Whereas, the untimely passing of Mr. Herbert precluded the according of this honor prior to his death; therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates elect Mr. J. Joseph Herbert to honorary membership in the Michigan State Medical Society posthumously; and be it further

"RESOLVED: That this membership be presented to his widow, Mrs. Imogene Herbert."

This was referred to the Reference Committee on Special Memberships.

X—21. APPROVAL OF MEDIATION-ETHICS-GRIEVANCE COMMITTEE RECOMMENDATIONS

W. A. SCOTT, M.D.:

"Whereas, the Mediation, Ethics and Grievance Committee of The Council of MSMS has recommended the consideration of changes in Chapter 6 of the Michigan State Medical Society Bylaws and the addition of a Chapter 7 with subsequent re-numbering of the remaining Chapters, and

"Whereas, the purpose of these changes is to provide a simple and fair mechanism for handling minor offenses as well as more serious charges, and yet keep the Society protected in the event of court action; therefore, be it

"RESOLVED: That the recommendations of the Mediation, Ethics and Grievance Committee of the MSMS be approved by the House of Delegates."

This was referred to the Reference Committee on Constitution and Bylaws.

X—22. NEW MSMS HEADQUARTERS

W. A. Scott, M.D.:

"Whereas, increasing demands for service are being made upon the MSMS by the medical profession and the public, and

"Whereas, such demands must be met by well-planned and effectively executed programs, and

"Whereas, the administration of such programs must of necessity center in the Executive Office of MSMS, and

"Whereas, present Lansing facilities for the Executive Office are already strained to the utmost and unless expended shortly will hamper the efficient execution of MSMS programs, and

"Whereas, it is reliably estimated that a proper headquarters can be built and equipped for an amount approximating $300,000; therefore, be it

"RESOLVED: That a new MSMS headquarters be built and equipped in Lansing, Michigan; and be it further

"RESOLVED: That for the building of this new headquarters the sum of $300,000 be raised by:

"(1) The sale (at the proper time) of our present headquarters.

"(2) By the use of present building reserves.

"(3) By the increasing of dues in the amount of $5 per year, beginning in the 1957 fiscal year, said increase in dues to be used only for the purpose of defraying the cost of building and equipping a new MSMS headquarters."

This was referred to the Reference Committee on Miscellaneous Business.

X—23. REGULATION OF AMBULANCE OPERATION

G. H. Bauer, M.D.:

"Whereas, a number of accidents have occurred recently which involved speeding ambulances, and

"Whereas, these accidents constitute a hazard to the ambulance passengers and to the public, and

"Whereas, in the overwhelming majority of cases there is no medical justification for such hazardous operation of ambulances; therefore, be it

"RESOLVED: That the Michigan State Medical Society go on record as strongly urging more stringent regulation of ambulance operation by appropriate civil authorities."

This was referred to the Reference Committee on Legislation and Public Relations.

X—24. APPRECIATION OF THE LATE HENRY A. LUCE, M.D.

A. H. Price, M.D.:

"Whereas, with the death of Henry A. Luce, M.D., the medical profession has lost a most valued friend and leader, and

"Whereas, Dr. Luce for years served faithfully and capably in this House of Delegates as delegate from Wayne County, as President of the Michigan State Medical Society, as delegate to the American Medical Association for eighteen years, as a member of the Special Study Committee of Medical Services in England, France and Italy, and in many other responsible assignments; therefore, be it

"RESOLVED: That this House of Delegates express its deep appreciation for the faithful work and the inspiring leadership of Dr. Luce and its sorrow at his passing; and be it further

"RESOLVED: That a copy of this resolution be sent to the family of Dr. Luce."

This was referred to the Reference Committee on Miscellaneous Business.

X—25. ADEQUATE FUNDS TO CARRY OUT CIVIL DEFENSE

Louis Jaffe, M.D.:

"Whereas, a well-developed civil defense is imperative for the survival of this nation in the event of enemy action against civilian populations, and

"Whereas, the State of Michigan contains within its boundaries several areas of prime importance to national survival, and

"Whereas, medical planning for the care of mass casualties and displaced populations is a major factor in civil defense, and will require the potential of the entire State of Michigan, and

"Whereas, the Department of Health of the State of Michigan is the logical agency to direct and to stimulate medical planning in the State, and to integrate medical facilities in the event of enemy attack or in natural disaster; now, therefore, be it

"RESOLVED: That the Legislature of the State of Michigan be respectfully requested to appropriate annually sufficient funds to the State Health Department so that it may discharge its responsibilities in the medical aspects of civil defense."

(See Reference Committee Amendment, Page 1533).

This was referred to the Reference Committee on Legislation and Public Relations.

X—26. PERMANENT ADVISORY COMMITTEE ON FEES

E. H. Fenton, M.D.:

"Whereas, inequities exist in professional fee schedules, and

"Whereas, the monetary value of medical and surgical procedures fluctuates, and

"Whereas, it is impractical to remedy these inequities without considerable study, and

"Whereas, certain dissatisfactions within the profession could be minimized by a continuing consideration of these fee schedules, and

"Whereas, a temporary committee has inadequate time to consider the problem; therefore, be it

"RESOLVED: That the Michigan State Medical Society establish a permanent Advisory Committee on Fees."

(See Reference Committee amendment. Page 1532).

This was referred to the Reference Committee on Resolutions.

X—27 (Const. Art. X, Sec. 1, 2, & 3) TO MAKE VICE SPEAKER A VOTING MEMBER OF THE COUNCIL AND OF ITS EXECUTIVE COMMITTEE

A. S. Narotzky, M.D.:

"Whereas, the Vice Speaker of the House of Delegates of the Michigan State Medical Society is presently a member of The Council and the Executive Committee but without power to vote, and

"Whereas, The Council, desiring broader representation of the House of Delegates on the Executive Committee has recommended that the Vice Speaker be given full membership on The Council and the Executive Committee, therefore be it

"RESOLVED: That the House of Delegates take action to amend the Constitution and Bylaws to make the Vice Speaker of the House of Delegates a member of The Council and the Executive Committee by amending Section 1 of Article X of the Constitution by inserting the words 'and Vice Speaker' after the word 'Speaker'; by amending Section 2, Article X of the Constitution by striking out the words 'and the' preceding the word 'Speaker' and inserting after the word 'Speaker' the words 'and Vice Speaker'; by deleting

Section 3 of Article X of the Constitution; and by amending Section 1 of Chapter 9 of the Bylaws by inserting the words 'and Vice Speaker' after the word 'Speaker.' "

This will be laid in the record and will not be considered further at this session because it is a Constitutional amendment, and it will come up in next year's House of Delegates for action.

X—28. URGING TOTAL PARTICIPATION OF M.D.'s IN MMS

J. R. Heidenreich, M.D.:

"Whereas, there is an apparent lack of full understanding and appreciation of the basic principles and philosophy of Michigan Medical Service by at least 1,200 Michigan doctors of medicine, and

"Whereas, the Michigan State Medical Society in the early and late 1930s developed the only prepayment plan that has sustained the private practice of medicine, and

"Whereas, this work of the pioneers in the prepayment field of medical care is obviously in serious jeopardy through the current activities of outside pressures promoting schemes and the use of controls at variance with organized medicine, and

"Whereas, organized medicine has maintained this prepayment plan of medical-surgical and obstetrical care which is controlled by the Society to which we belong and which still retains a strong voice in the determination of the policies of Michigan Medical Service and the setting of fees and conditions under which fees shall and shall not be paid, and

"Whereas, this plan was proclaimed by the late Senator Arthur Vandenberg as 'Michigan's greatest public trust,' and a very important reason why legislation in the United States Senate has not been passed which might have been detrimental to the private practice of medicine, and

"Whereas, we in the Upper Peninsula Medical Society who are enrolled 100 per cent do not feel that our colleagues in some of the metropolitan areas of the Lower Peninsula are supporting Michigan Medical Service with the same enthusiasm as is found in our community, and

"Whereas, it must be the contribution of each and every member of this Medical Society, either in the Upper Peninsula or in the Lower Peninsula, to assist, promote, improve and actively participate with the service principles of Michigan Medical Service since such service principles have been acknowledged as the basic reasons why nearly 3½ million Michigan people have the protection sponsored by the Michigan State Medical Society rather than inferior indemnity insurance or plans which might have been instituted should the doctors' own plan have failed; therefore, be it

"RESOLVED: That the Michigan State Medical Society recommend to each of its component county medical societies that they engage in an active campaign to obtain the highest percentage of participation possible within their organizations, in addition to a forthright effort, to be certain that doctors who already participate understand what their participation means to themselves as individual private practitioners of the science and art of medicine, what it means to their patients to have a system for the prepayment of their medical-surgical and obstetrical expenses, what it means to the practice of medicine as we now enjoy it as a free enterprise where free men are disciplined men but still are free men, and what it will mean to our sons who are or may become doctors of medicine; and be it further

"RESOLVED: That this State Medical Society, its members and officers assist each county in its campaign to see that Michigan Medical Service remains as the most successful prepayment plan for the expense of medical-surgical and obstetrical care and by such success reduce the threat of interference of less desirable schemes by proving their lack of ability to match or even come close to what is and can only be provided by doctors of medicine through their own agency, Michigan Medical Service."

This was referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—29. (ByLaws, Chapter 8, Section 10-J) CHANGING NAME OF A HOUSE OF DELEGATES REFERENCE COMMITTEE (National Defense and Disaster Planning)

M. L. Lichter, M.D.:

"Whereas, the Reference Committee on Emergency Medical Service, as provided for in Chapter 8, Section 10-j No. 13 of the Bylaws is not an accurately descriptive name for the function it is to perform; therefore, be it

"RESOLVED: That Chapter 8, Section 10-j No. 13 of the Bylaws be amended to read, 'National Defense and Disaster Planning.' "

This was referred to the Reference Committee on Constitution and Bylaws.

X—30.—URGING TOTAL PARTICIPATION OF M.D.'S IN MMS (Bowman)

D. A. Bowman, M.D.

"Whereas, I was at one time not in sympathy with some of the principles of Michigan Medical Service, which was before I became exposed to the background and philosophies of Michigan Medical Service just one year ago when I attended my first State Medical Society meeting as a delegate from Bay County, and

"Whereas, there are many physicians, especially in the young age group, who feel as I did previously, and

"Whereas, those early pioneers who put prepayment on a voluntary basis and in the hands and control of the medical profession are gradually fading from the scene, and must be replaced by doctors who must learn the philosophies and principles through their association and tutelage of our senior Society members, and

"Whereas, in view of current attempts to impose a type of police force on the practice of medicine, or replace the voluntary idea with a system controlled and directed by persons not in sympathy with the ideals and ideas of medical organization, and

"Whereas, the survival of the voluntary system of prepayment medical care depends on a unity within this State Medical Society which does not now exist to the extent which is necessary, due to the absence of a thorough understanding of the basic philosophies of Michigan Medical Service by younger physicians; therefore, be it

"RESOLVED: That the Michigan State Medical Society stop at nothing short of getting 100 per cent participation in Michigan Medical Service of all of the members of this Society, and put on a concerted drive to thoroughly indoctrinate each and every doctor of medicine who is a member of the Michigan State Medical Society in his obligation to himself, his patients and his Society by living up to and conforming to the rules, regulations and practices of Michigan Medical Service, and to convince each private practitioner of medicine, with emphasis on the younger men, that a sacrifice of a few dollars today, in an era of prosperous medical practice, will prevent the loss of more than just dollars should this voluntary system fail."

This resolution was referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—31. ANNUAL REGISTRATION OF M.D.'s

O. J. Johnson, M.D.:

"Whereas, under the present system of initial registration of doctors of medicine it is difficult for the State Board of Registration in Medicine to keep ac-

curate records of physicians and their location of practice, and

"Whereas, accurate information about doctors of medicine is necessary to locate illegal practitioners, and

"Whereas, it is estimated by the State Board of Registration in Medicine that there are several hundred illegal practitioners in the State, and

"Whereas, such information will be valuable to civil defense authorities for mobilization in the event of disaster or like emergency, and

"Whereas, thirty-eight states have enacted legislation for the annual registration of doctors of medicine; therefore, be it

"RESOLVED: That this House of Delegates approves legislation to provide for the annual registration of doctors at a fee which will provide sufficient funds to carry out its provisions, but such fee not to exceed $5."

This was referred to the Reference Committee on Legislation and Public Relations.

(Vice Speaker K. H. Johnson, M.D. (Ingham), assumed the Chair.)

XI. REPORTS OF STANDING COMMITTEES

XI—1. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

The first report is that of the Committee on Postgraduate Medical Education, found on page 95 of your Handbook. This Committee's report will go to the Reference Committee on Reports of Standing Committees.

XI—2. COMMITTEE ON PREVENTIVE MEDICINE AND SUBCOMMITTEES

The report of the Preventive Medicine Committee and its subcommittees is found on page 99 of the Handbook. This report as printed will go to the Reference Committee on Reports of Standing Committees.

XI—3. PUBLIC RELATIONS COMMITTEE AND SUBCOMMITTEES

The report is on page 115.

XI—4. ETHICS COMMITTEE

The Ethics Committee's report is on page 122.

XI—5. LEGISLATIVE COMMITTEE

The report of the Legislative Committee is on page 123.

XII. REPORTS OF SPECIAL COMMITTEES

XII—1. SCIENTIFIC RADIO COMMITTEE

The report appears on page 126.

XII—2. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The report of this committee appears on page 127.

XII—3. ADVISORY COMMITTEE TO THE MICHIGAN MEDICAL ASSISTANTS SOCIETY

The report of the Advisory Committee to the Michigan Medical Assistants Society is found on page 128 of the Handbook.

XII—4. COMMITTEE TO STUDY MSMS FINANCIAL STRUCTURE

O. K. ENGELKE, M.D.:

This report of the Special MSMS Committee to Study Finances and Dues of the Michigan State Medical Society should be qualified with this understanding: Throughout this report we use the words "reserve funds" or "surplus funds." With the idea that these are monies the Committee describes as being available to the Michigan State Medical Society in fairly fluid form, the word "reserve" does not have the same meaning in this report that it may have in reports of The Council.

I repeat: The word "reserve" and the word "surplus" as found in this report have a different meaning than some special funds designated as reserve funds by The Council of the Michigan State Medical Society. We use these words in this report to designate funds that are in fairly fluid form, readily available to the Society in the event of any type of emergency, change in program, and so on.

This Committtee was authorized by the 1955 House of Delegates in an amended amendment to the motion to accept the original report of The Council as well as a supplemental report relative to a proposed $10 increase in dues. (Dr. W. W. Babcock's amendment, amended by Dr. O. J. Johnson.)

Working members of the Committee appointed by Speaker J. E. Livesay, M.D., are: Otto K. Engelke, M.D., of Washtenaw, Chairman; C. W. Colwell, M.D., of Genesee; E. H. Fenton, M.D., of Wayne; Earl G. M. Krieg, M.D., of Wayne, and H. J. Meier, M.D., of Branch.

This Committee has met five times since March 20. Attendance has been excellent, with but one or two absences recorded. All meetings were held in executive session except the first and third. At the Committee's request, these two meetings were held at the MSMS Lansing office where resource people and important data were available.

State officers and staff personnel called to the first meeting were: D. Bruce Wiley, M.D., Chairman of The Council; Ralph W. Shook, M.D., Chairman of the Finance Committee; L. Fernald Foster, M.D., Secretary; William J. Burns, Executive Director; Hugh W. Brenneman, Public Relations Council, and R. J. Roney, Assistant Executive Director.

Dr. Foster, Mr. Brenneman, and Mr. Roney were called to the third meeting. All other Committee sessions were held at Ann Arbor, with Committee members only in attendance. No Society-purchased liquor was consumed at any of our meetings. (Laughter). This was found to be the policy in effect at all similar Society functions.

The officers and staff members of the Society gave full co-operation. Financial reports, budgets, auditors' statements, special Society reports, material from professional and other Michigan organizations, medical societies from other states, and special bits of relative data were promptly supplied to the Committee. Legal counsel was given by the late Mr. J. Joseph Herbert.

I would like to add that the minutes of the meetings of this Committee are in good order, and subsequent to the wishes of the Speaker of the House of Delegates may be placed at your disposal, if it is so decided.

The first meeting was dedicated to a general discussion of the problems by resource people as well as a review of Society budgets back through 1953, item by item. Additional information was requested, as here listed:

A—An individual salary breakdown.

B—Summary of employes' retirement first costs.

	Total	Society Share	Employe Share
Premium—1 year	$19,833.41	$10,663.25	$9,170.16
Refund—Deceased employe	891.54	448.38	443.16
NET COST	$18,941.87	$10,214.87	$8,727.00
Monthly collections from employes	7,890.35		7,890.35
	$11,051.52		$ 836.65
Due from employes in January, 1956	836.65		836.65
	$10,214.87	$10,214.87	—0—

C—Brief outline of each employes' duties.

Brief Outline of Duties of MSMS Executive Office Personnel

WILLIAM J. BURNS, Executive Director, executes all details of the progressive program devised by the House of Delegates and The Council of the Michigan State Medical Society, as assigned to him by the Secretary (per Bylaws, Chapter 11, Section 8.)

HUGH W. BRENNEMAN, Public Relations Counsel, administers the public relations and central educational program of the Michigan State Medical Society, and helps to promote cordial liaison between MSMS and other medical, health, professional and trade organizations, usually working on the administrative level. Acts as secretary to certain MSMS committees at their meetings.

WARREN F. TRYLOFF, Public Relations Field Secretary, represents MSMS in central educational activities, works in public relations programs of MSMS and acts as liaison with Wayne County Medical Society and fourteen others in Southeastern Michigan. Acts as secretary to certain MSMS committees at their meetings.

RICHARD N. PHILLEO, Public Relations Field Secretary, represents MSMS in central educational activities, works in public relations programs of MSMS, and acts in liaison capacity with thirty-three county medical societies and MSMS.

A. DEWITT BREWER, Associate Public Relations Counsel, helps to plan and carry out MSMS public relations program. Writes MSMS news releases, press kits, and prepares copy for various brochures and other MSMS publications. Serves as field secretary for nine county medical societies and staff liaison with MSMS Woman's Auxiliary. Acts as secretary to various committees and committee meetings. Works with various phases of MSMS central educational program.

ROBERT J. RONEY, Assistant Executive Director, handles JOURNAL advertising and proofreading, all membership records, including correspondence, and Directory publications. In charge of building maintenance and supplies purchasing. Also of books of accounts and processing of checks and records of financial transactions.

HELEN SCHULTE, Administrative Assistant, chief Secretary to Executive Director; supervisor of stenographers' pool; organizes all scientific programs for annual sessions and Michigan Clinical Institutes.

GERALDINE CHAPMAN, Secretary to Executive Director, handles committee meetings, including notices, agenda, room reservations; correspondence and records for technical exhibits at conventions, and general correspondence.

JEAN MACDONALD, Secretary to Public Relations Counsel, also supervises distribution of literature, films and other public relations media. Works closely with the Michigan State Medical Assistants Society.

MARILYN J. LEWIS, member of stenographic pool, head telephone operator and receptionist; transcribes cylinders—Mr. Burns and Mr. Roney; proofreads stencils of all committee minutes; types stencils.

VADA STUDT, member of stenographic pool; secretary of Lansing Rheumatic Fever Center (correspondence with doctors referring patients and with patients, setting up clinic dates with hospital and with patients, notifying clinic members of meeting dates, attending monthly clinics and consultation meetings which follow, transcribing reports on patients, and keeping Lansing Center records); transcription of cylinders for Mr. Burns and Mr. Brewer; filing of committee minutes and correspondence; posting of memberships.

THERESA KRZESICKI, member of stenographic pool; types committee minutes stencils and proofreads, mimeographs minutes and forwards minutes to committee members and members of The Council; makes address changes for MSMS membership; sends out membership cards to MSMS membership, types stencils, copy work, and other typing.

MARGARET CORNWELL, member of stenographic pool; files all newspaper clippings, types routine form letters requesting copies of pamphlets, etc.; does all mimeographing; collects and folds all mail twice daily; types stencils and other materials.

ARNOLA MACQUEEN (starts work at MSMS on May 28), member of stenographic pool; second telephone operator and receptionist; will transcribe cylinders, type stencils, and other typing.

AGNES HILL, secretary to Warren F. Tryloff (in Detroit office).

STANLEY GUSTAFSON (part-time), mail clerk, equipment operator.

JACK MCMANUS (part-time), janitor.

Other MSMS employes (part-time) who are not housed in Executive Office are: Secretary L. Fernald Foster, M.D., Bay City; Editor Wilfrid Haughey, M.D., Battle Creek; Rheumatic Fever Co-ordinator Leon DeVel, M.D., Grand Rapids (plus five Rheumatic Fever Center secretaries); and Legal Counsel J. Joseph Herbert, Manistique.

D—List of dues from medical societies of other states.

DUES AND SPECIAL ASSESSMENTS OF STATE MEDICAL ASSOCIATIONS AS OF MAY 16, 1956

State	*Dues*	*Special Assessments*	*Comments*
Alabama	$20	—0—	Dues $50 effective 1/1/57
Arizona	60	—0—	Dues $70 effective 1/1/57. Extra $10 for AMEF
Arkansas	25	—0—	
California	50	—0—	
Colorado	50	—0—	
Connecticut	28	$10 voluntary assessment for building addition	
Delaware	50	—0—	
Florida	40	—0—	
Georgia	25	—0—	
Idaho	40	—0—	
Illinois	40	—0—	
Indiana	30	—0—	
Iowa	60	—0—	$25 increase authorized but not levied as yet
Kansas	40	—0—	
Kentucky	35	—0—	
Louisiana	50	—0—	
Maine	35	—0—	It is planned to raise the dues to $60 this June
Maryland	Baltimore City members, $50 County Society members, $30	—0—	
Massachusetts	35	—0—	
Michigan	45	$10 assessment for 1956 only	
Minnesota	40	—0—	
Mississippi	35	—0—	Dues to be increased $5 per year for 3 years: 1957, $40; 1958, $45; 1959, $50
Missouri	25	$10 assessment for 1957 only	
Montana	53.50	—0—	
Nebraska	35	—0—	
Nevada	100	$20 (AMEF)	
New Hampshire	40	—0—	
New Jersey	30	—0—	

New Mexico	70	—0—	
New York	25	$10 assessment (effective 1/1/57) to be used for employes' pension fund	
North Carolina	40	—0—	
North Dakota	75	—0—	
Ohio	20	—0—	Dues $25 effective 1/1/57
Oklahoma	42	—0—	
Oregon	40	—0—	
Pennsylvania	40	—0—	
Rhode Island	50	—0—	
South Carolina	20	—0—	
South Dakota	75	—0—	
Tennessee	25	—0—	
Texas	50	—0—	
Utah	50	$20	
Vermont	35	—0—	
Virginia	25	—0—	
Washington	35	—0—	
Washington D. C.	50	—0—	
West Virginia	25	—0—	
Wisconsin	65	—0—	
Wyoming	25	—0—	

E—Employes roster for 1954-1956.

F—From all sources, justification of the need for a reserve for two years. (See Burns letter of May 16 for conclusion).

"The immediate following paragraphs on *Budgeting for Reserves* were printed in the National Institute's 'bible,' called *Trade Association Management.*" (From Wm. J. Burns to Dr. Otto K. Engelke, May 9, 1956).

Budgeting for Reserves

It is generally recognized that an association should build up a reserve ample enough to meet the following needs: (1) To provide adequate working funds; (2) to act as a cushion to take care of unanticipated expenditures, and (3) to furnish adequate funds to carry the organization through a depression period without too great a curtailment of activity.

In the course of events, there can never be complete certainty that the necessity for unanticipated expenditures may not arise during the next fiscal year. It is undesirable that each annual budget should have to provide substantially for unknown contingencies. Therefore, most trade associations try to build up, year by year, a reserve for unanticipated expenditures to a point sufficient in due time to eliminate any necessity for inclusion in each current year's budget of a special amount for unknown contingencies.

Reserve Funds

Approximate Percentage of Annual Budget

A Study of 255 Associations by the U. S. Chamber of Commerce

Percentage	*Number of Associations*	
Under 10	24	
10-20	18	125 below MSMS group in reserve funds.
21-30	14	
31-40	19	
41-50	31	
51-60	9	
61-70	10	
71-80 (MSMS 74%)	15	MSMS here
81-100 (Dec., 1956)	78	Largest single group
101-150	8	
151-200	16	
201-250	1	
251-300	6	120 above MSMS group in reserve funds.
301-400	4	
Over 400	2	
	255	

In addition, it is generally agreed that associations should establish a reserve sufficient to meet the minimum costs of operation for a period of at least one year so that, should adverse conditions such as those imposed by a severe depression occur, it may be possible substantially to reduce the income budget even while the expense budget is maintained. The future of the organization is thus assured by providing a source of funds from which part of the necessary costs of operation could be met for each of several years, if necessary.

Special Note From Committee

$360,000 approx.—MSMS average rate of expenditure per year.

225,000 approx.—MSMS reserve late in December, 1955, when finances are traditionally at lowest ebb.

12,000 approx.—Income not included in 5,000 paid member estimate for 1956.

50,000 approx.—To be placed in reserves ($7.50 per paying member out of $10 assessment.)

$287,000 approx.—Reserve anticipated December, 1956.

* END OF NOTE *

The establishment of a reserve sufficient to meet these purposes for a period of two years may best be accomplished by including in the budget, each year for a sufficient number of years, funds adequate to establish a reserve for contingencies and unanticipated expenditures accruing up to one or two years of a normal budget. The best practice is frankly to include in the budget each year, until the required reserve is fully established, an amount sufficient to obtain the desired reserve in a reasonable time.—*Trade Association Management*

At the next meeting much additional information was requested on pertinent items. A few examples are here listed:

1. The production of the movies by the MSMS staff, the necessity of such movies and their cost compared to the others available from the AMA.

Production of Movies by MSMS.—Mr. Brenneman gave the following information: First movies were in opposition to socialized medicine and were "To Your Health"—cost $15,000, and "Lucky Junior"—cost $11,000. (Nothing on these subjects was available from any source.)

"To Save Your Life"—$4,000. This was double length and in color.

"In Planning Your Career"—$2,200.

One on "Epilepsy" is now 75 per cent completed and will cost about $2,500. Two more have been authorized, as follows: (a) "Cost of Medical Care"; (b) "Periodic Health Appraisal."

No movies have been completed that could have been gotten from the AMA or other source. The MSMS was first in the field of film productions.

The Committee explained the use of their movies. Explanations were generally satisfactory.

2. Expenditures of the MSMS funds in recent news releases refuting inaccurate information released by certain newspapers regarding Blue Cross and Blue Shield.

News Releases re Blue Cross-Blue Shield.—Only one was made, and that was purely educational and a good investment.

Two others were not prepared (action of Executive Committee). The cost of the one in about six newspapers cost $4,500—one-half of which was paid by MSMS.

3. A more detailed explanation of the securities on hand at the end of the calendar year with expenses anticipated for the first quarter of the new calendar year and the securities on hand at the end of the first quarter with respect to programs anticipated for the balance of the calendar year.

Securities on Hand.—Mr. Roney discussed this, and it was developed that in December 1955 (low period of

funds) the Society had a total of $225,000 in all funds. Financial report and budget studies also indicated a reserve of $275,000 to $300,000 at the end of 1956.

4. The possibilities of income tax liabilities, were a $600,000 financial surplus established. The Committee requested a legal opinion from Mr. Herbert on this matter.

LETTER FROM MR. HERBERT TO DR. ENGELKE

June 8, 1956
127 South Cedar Street
Manistique, Michigan

Otto K. Engelke, M.D.
720 E. Catherine Street
Ann Arbor, Michigan

Dear Dr. Engelke:

This letter is in confirmation of an oral opinion which has doubtless been relayed to you by Mr. Hugh Brenneman.

The Committee on the Study of the MSMS, of which you are Chairman, has raised two questions:

1. Does the income derived by the MSMS, from dues and assessments in excess of immediate annual needs, or the accumulation of such income, become subject to federal income tax?
2. Is the income derived from such accumulated reserve fund subject to federal income tax?

Michigan State Medical Society has been certified by the Internal Revenue Service as a corporation exempt from tax under provisions of Section 501 (c) (6), Internal Revenue Code 1954. At the time of the exemption the identical provision appeared as Section 101(7), Internal Revenue Code 1939. The Society was classified as a "business league" within the meaning of the subsection.

So long as the Society does not alter its activities from that in which it was engaged at the time it was classified and exempted, the exemption from federal tax remains. As far as I know, there has been no change.

The only other situation which would give rise to federal income tax appears in Sections 511, 512 and 513, I.R.C. 1954. These sections provide for an exception when a corporation exempted under Section 501 has "unrelated business taxable income."

"Unrelated trade of business" is defined in Section 513 as "any trade or business, the conduct of which is not substantially related * * * to the exercise or performance by such organization of its charitable, educational or other purpose or function constituting the basis for its exemption under Section 501."

"Unrelated business taxable income" is defined by Section 502 as "the gross income derived by any organization from any unrelated trade or business regularly carried on by it." However, there is excluded from such income "all dividends, interest and annuities and all deductions directly connected with such income." Section 512(b) (1).

The income to which your question is directed is obviously not "unrelated taxable business income" as defined by statute. Moreover, the income derived from the accumulations in the reserve fund consists merely of interest or dividends.

It is my opinion, therefore, that the answer to both of your questions is "no."

Very truly yours,
s/ J. JOSEPH HERBERT, *Legal Counsel*

5. The value of the field representatives of the MSMS to the public relations programs of Wayne County and other local areas in the State. The public relations program of Wayne County and its relationship to the State public relations program. The virtues of an MSMS refund to such counties for local public relations programs.

Value of Public Relations Field Representatives to Public Relations of Wayne County and Other Parts of State.—Mr. Brenneman explained these activities in detail.

The Committee concluded that public relations are a Statewide activity, regardless of the size and other conditions of local areas.

6. An explanation of the preprandial activities of the several meetings of the State organization.

Preprandial Expenses.—It was determined that it was the policy of MSMS to pay for no preprandial activities except at specific gatherings where MSMS was host to groups—e.g., Exhibitors Gridiron, Press Dinners, Health Officers' Reception, et cetera.

7. The costs of the Mackinac Island summer meeting.

Expense of Mackinac Island Council Meeting.—Secretary Foster announced that a check on costs showed that the meeting at Mackinac Island was scarcely more expensive than if held in Detroit. Better attendance made for a better meeting.

The Society committee membership activity and other "in-service" educational activities were discussed. Expenses allowed participants were frugal when compared with time and income lost by most committees and other members in addition to benefits accruing nonworking members and the public.

8. Expenditures of the Osteopathic Society, such as dues, assessments, etc., as well as similar expenditures by the State Dental Society, State Bar Association and others.

Other Society Dues.—Mr. Brenneman gave the following information:

Bar Association—8,000 members, $15 dues plus $5 each of four sections plus $25 building fund. Total, $60.
Dental Society—3,200 members, $25. No activities. One executive secretary and one stenographer.
Osteopathic Society—$300 per year.

9. Justification of the two-year surplus and requirement along with the statement of the surplus condition of Ohio, New York and California. A statement regarding the time interval which should be used building up the recomemnded surplus.

Justification of Two Years' Surplus.—California has $1,000,000 in reserves. Ohio has $90,000 in reserve and is raising dues $5 this year to 8,200 members which will add about $40,000 more. The MSMS has established no time limit on when to have reserve fund completed.

10. The history of the use of the contingent fund.

11. An explanation of anticipated commitments in the public relations programs.

12. A concise statement regarding the public relations program.

Subsequently, additional material was requested regarding state societies in whose jurisdiction there are medical schools to see if there is a problem of dues with full-time faculty members having low incomes.

In the states of New York, Ohio and Texas there are no special memberships for faculty members or those on low fixed incomes aside from those in military service or in training normally as civilians for a limited number of years.

The California situation is as follows:

L. Fernald Foster, M.D., Secretary
Michigan State Medical Society
606 Townsend Street
Lansing 15, Michigan

Dear Fern:

In reply to your letter of July 6, the California Medical Association does not maintain a separate

membership classification for full-time medical school professors. However, we do have a classification of Associate Membership which is available to faculty members, public health officers, ad others who are engaged in full-time administrative work and who do not engage in the private practice of medicine. These members pay one-half the annual dues for active members and are carried as Associate Members of the AMA, paying no AMA dues. Most of our county societies also reduce the dues of these members to one-half those for active members.

I hope this information will be helpful to you.

Cordially yours,
s/ JOHN HUNTON, *Executive Secretary*

The Medical Society of Pennsylvania is as follows:

"We do not have any special types of membership such as you have in mind. Faculty members who are licensed to practice in Pennsylvania pay full dues if they belong to the county medical society, State Medical Society, and American Medical Association regardless of whether they are full-time or part-time faculty members and whether or not they engage in private practice. They are considered as active, dues-paying members.

"You will note in the second paragraph, top of page 8, that active members who are serving hospital residencies pay 40 per cent of the regular assessment during the period of training, if such training is begun during any of the first five years following graduation from medical school. Section 2 on page 8 gives the qualifications for Associate Membership.

"On page 10 you will find in Section 3 our definition of Affiliate Members. Please note the sentence half way down the paragraph: 'They shall be doctors of medicine not holding license to practice in Pennsylvania.' Many faculty members are Affiliate Members, provided they are not licensed to practice in Pennsylvania. Section 4 on page 10 described Honorary Members.

"Very sincerely yours,
Secretary-Treasurer"
"s/ HAROLD B. BARDNER, M.D.

The Illinois situation is as follows:

"We handle all applications for consideration for a 'cut' in dues on the individual basis—as 'hardship' cases. This covers the older men returning for residency training who don't qualify under the Constitution and Bylaws, and younger teachers on a full-time basis who are not paid enough to absorb their dues in the ISMS, and the AMA and county society. We have very few in either group; in fact, the older residents are much more frequent than the full-time teachers.

"Yours very sincerely,
"s/ HAROLD M. CAMP, M.D.
Secretary

Wisconsin has as follows:

CONSTITUTION AND BYLAWS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Chapter VIII—Dues and Assessments

Section 5. *Educational Memberships*

Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

Membership and income figures for the depression and war years were received to determine the effect of hard times and membership depletion in the resources of the society.

For: Committee to Study MSMS Financial Structure
July 2, 1956

UNPAID MEMBERS OF THE MICHIGAN STATE MEDICAL SOCIETY 1928-1938

Year	*Total Members*	*Unpaid Members*
1928	3,457	Not available
1929	3,463	Not available
1930	3,417	250
1931	3,235	335
1932	3,293	234
1933	3,160	450
1934	3,393	175
1935	3,650	138
1936	3,725	141
1937	3,963	144
1938	4,205	115

COMPARISON OF MEMBERSHIP AND NUMBER OF MILITARY MEMBERS DURING WORLD WAR II PERIOD

(Military Members were granted remission of membership dues)

* * *

1939	4,425	–0– Military
1940	4,527	–0– Military
1941	4,621	209 Military
1942	4,714	1,127 Military
1943	4,786	1,142 Military
1944	4,702	1,151 Military
1945	4,686	1,353 Military
1946	4,799	130 Military
1947	4,797	103 Military
1955	6,109	430 Military & Associate

POPULATION FIGURES FOR MICHIGAN

April 1, 1930	4,842,325
April 1, 1940	5,256,106
April 1, 1950	6,371,766

It will be noted that unpaid memberships reached a peak of 450 during the depression, less than 20 per cent of members, and that military nonpaying members reached an average of about 26 per cent for four years during the last war.

It is conceivable that during the next war this figure may be much higher, with many doctors pressed into military and civilian defense duties.

Salaries of the executive staff of the MSMS and member officers were received. Comparisons were drawn with other societies with activities compared to those of the MSMS. The Committee found that rather than being overpaid, our Society was very conservative in its reimbursement of these men. Lower echelon paid staff salaries and benefits were found to be in line with others in similar jobs in Lansing.

Other facets of Society program, operation and financing too numerous to mention, were studied. Delegate activities, alternate delegate activities, as well as public education, public service, professional relations and such programs designed to educate lay people representing all areas in the State were examined and found to be sound.

The Committee has noted the recent signs of a continuation of the inflationary spiral. Maintenance of current program will of necessity cost more.

The Committee discussed at great length the complexity of the budget and financial reports as well as the location of the reserves therein.

Conclusions

1. The officers and professional staff of the MSMS are to be commended for their leadership in a program which is sound and well administered.

2. The part-time officers and full-time key professional staff are under-paid rather than over-paid. The AMA delegates and alternates as well as members of The Council, committees and others active in the Society make a very valuable contribution to the public and

Society welfare at a significant personal sacrifice in most instances.

3. Evidence was not produced to justify a reserve equal to two years of Society operation.

4. The current $45 dues and $10 assessment has placed the Society in good condition financially, with a reserve anticipated for December of 1956 of approximately $275,000 to $300,000. During times of stress, such as the last depression or last war, this will permit Society operation at the current level for at least three to four years with a curtailment of 25 per cent of income. With a reasonable curtailment of expenditures, one year's operation without any income whatever is possible. By the same token, a reasonable increase in program is possible with this reserve to meet any possible emergency in the interval between meetings of the House of Delegates.

5. The $10 assessment levied in 1956 should not be renewed.

6. A dues increase of $5 is recommended to protect this reserve, offset higher costs, to permit a continuation of program at its current level, and to adequately reimburse part-time officers, key full-time staff and others.

O. K. Engelke, M.D., *Chairman*
C. W. Colwell, M.D.
E. H. Fenton, M.D.
Earl G. M. Krieg, M.D.
H. J. Meier, M.D.

Mr. Chairman, I present this for the entire Committee to you, Mr. Speaker, and to the members of the House. (Applause)

Vice-Speaker Johnson: Dr. Engelke, I think I speak for the entire House when I say we appreciate the detailed manner in which you have gone into this matter and the precise way in which you have presented it. Thank you and your Committee.

This report of the Study Committee was referred to the Reference Committee on Miscellaneous Business.

X—32. BLUE SHIELD PLAN FOR DIAGNOSTIC OUTPATIENT SERVICES

J. D. Fryfogle, M.D.:

"Whereas, the original concept of Michigan Medical Service as a catastrophic insurance coverage is no longer true, and

"Whereas, the people of Michigan now accept prepaid health insurance and desire more complete insurance coverage through Michigan Medical Service, and

"Whereas, the preservation of control by the Michigan medical profession of prepaid medical insurance is desirable, and

"Whereas, the need for action is seen by the adverse publicity accorded our present program, and

"Whereas, Blue Shield has need for actuarial experience in any new plan proposed; therefore, be it

"Resolved: That the Michigan State Medical Society House of Delegates approve plans of Blue Shield to proceed with pilot projects of diagnostic outpatient services paid for by extended coverage."

This was referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—33. SUBMISSION OF HOUSE OF DELEGATES RESOLUTIONS IN ADVANCE

O. J. Johnson, M.D.:

"Whereas, resolutions introduced to the House of Delegates of the Michigan State Medical Society are misunderstood, and

"Whereas, the members of the House of Delegates would be able to study a printed copy of resolutions; therefore, be it

"RESOLVED: That resolutions to be introduced to the House of Delegates of the Michigan State Medical Society be submitted to the headquarters of MSMS at least two weeks before the annual meeting of the House of Delegates; and be it further

"RESOLVED: That mimeographed copies of these resolutions be given to each delegate at time of registration; and be it further

"RESOLVED: That the number of resolutions not thus submitted be kept at a minimum."

This was referred to the Reference Committee on Resolutions.

(The meeting was recessed at 3:40 p.m.)

MONDAY EVENING SESSION

September 24, 1956

The meeting reconvened at 8:20 p.m., J. E. Livesay, M.D., Speaker of the House of Delegates, presiding.

X—34. MEDICAL CLASSES AT UNIVERSITY OF MICHIGAN AND WAYNE STATE UNIVERSITY TO SEND REPRESENTATIVES TO HOUSE OF DELEGATES SESSIONS

H. F. Falls, M.D. (Washtenaw):

"Whereas, it is the avowed policy of the Michigan State Medical Society to disseminate information to present and future physicians pertaining to medical economics, medico-legal and other aspects of medicine, and

"Whereas, the indoctrination of medical students in such subjects is a highly desired objective of this policy; be it, therefore

"Resolved: That the House of Delegates invite the medical classes of Wayne State and the University of Michigan to elect delegates to attend the House of Delegates' sessions, and that these representatives serve without vote but participate fully in all the functions of this organization; and be it further

"Resolved: That the expenses of such delegates be defrayed by the Michigan State Medical Society."

This resolution was referred to the Reference Committee on Resolutions.

XIII. REPORTS OF REFERENCE COMMITTEES

XIII—1. ON OFFICERS' REPORTS

Frank J. Busch, M.D. (Saginaw):

XIII—1 (a) *President's Address.*—The Reference Committee wishes to commend the address of Dr. Jones. It was a progressive and forward-looking report, and an excellent address. It is the recommendation of this Reference Committee that Dr. Jones' suggestion to explore the possibilities of a new site and building in Lansing for MSMS should receive the support of the entire membership of MSMS. The saving of the Veterans' Hometown Care Program was aided greatly by the personal efforts of Dr. Jones, and is commendable.

XIII—1 (b) *President-Elect's Address.*—The address of President-elect Arch Walls, M.D., was excellent, and shows we are in good hands for the forthcoming year. His invitation to labor keeps the door open for labor unions to co-operate in conferences for better understanding of the problems of distribution of medical care.

XIII—1(c) *Report of Delegates to the AMA.*—The Reference Committee wishes to commend the report of the delegates of the AMA as given by Dr. Hyland, and the showing of the film aided the problem of intraprofessional relations and is recommended to be shown to every county society.

The complete report of the delegates of the AMA beginning on page 84 of the Handbook, should be read by each delegate.

XIII—1(d) *Report of Woman's Auxiliary.*—The report of the Woman's Auxiliary was an inspiration.

Attention is called to their very successful effort in the Dimes Campaign and the gift of $3,200 to the American Medical Education Foundation. They surely had a good year.

XIII—1(e) *Report of Michigan State Medical Assistants Society.*—The report of the Michigan State Medical Assistants Society was excellent. They are expanding rapidly, as evidenced by their new chapter in the Upper Peninsula and the increase in each of their other groups. They are serving the needs of the doctors of medicine more efficiently each year.

The Reference Committee report was adopted by the House of Delegates.

XIII—2. ON REPORTS OF STANDING COMMITTEES

E. A. Oakes, M.D. (Manistee):

XIII—2(a). COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

The Reference Committee approves the annual report to be found in the Handbook.

XIII—2(b). PREVENTIVE MEDICINE COMMITTEE AND ITS SUBCOMMITTEES

(a) *Committee on Rheumatic Fever Control.* The Reference Committee reviewed their report and accepted it.

(b) *Cancer Control Committee.* The Reference Committee accepted this report.

(c) *Maternal Health Committee.* The Reference Committee accepted this report.

(d) *Veneral Disease Control Committee.* The Reference Committee wishes to delete three words at the bottom of page 104, "the diagnosis of" as being meaningless. Otherwise, the Reference Committee accepts the report.

(e) *Tuberculosis Control Committee.*—The report of this Committee, in the last paragraph on page 106, No. 1, was considered unsatisfactory and ambiguous, and not acceptable. The report states: "That excess beds be used for treatment and care of diseases which will permit flexibility of the utilization and of the beds to meet varying and largely unpredictable demands of tuberculosis."

We considered that this No. 1 is unsatisfactory and ambiguous, and do not believe it is acceptable.

To add to that, at the bottom of page 107, under "X-ray Survey Project in Southeastern Michigan," the Reference Committee felt this was not acceptable as written, and the following paragraph was presented by an adviser to the Reference Committee and was accepted in its place:

"Plans for a mass x-ray survey to be conducted in Southeastern Michigan in June, 1956, were discussed. It was agreed by the Committee that, recognizing that the 70 mm x-ray is a screening device for detecting tuberculosis, and recognizing that the effectiveness of a mass survey is better served by taking a 14 x 17 film where there is suspicion of chest disease for purposes of better identification, this particular project be authorized to use 14 x 17 film in the retakes as part of the survey project."

The Reference Committee moves the adoption of this report as amended.

(f) *Industrial Health Committee:* The Reference Committee accepts this report.

(g) *Mental Health Committee:* The Reference Committee accepts this report.

(h) *Child Welfare Committee.* The Reference Committee approved this report.

(i) *Iodized Salt Committee.* The Reference Committee approved this report.

(j) *Geriatrics Committee.* The Reference Committee approved this report.

XIII—2(c). PUBLIC RELATIONS COMMITTEE AND ITS SUBCOMMITTEES

The report of this committee and its subcommittees was approved by the Reference Committee, which felt that it had done a wonderful job.

XIII—2(d). ETHICS COMMITTEE

The report of the Ethics Committee was approved by the Reference Committee.

XIII—2(e). LEGISLATIVE COMMITTEE

The Reference Committee approved this report.

Finally, the Reference Committee moved the adoption of the report as a whole, as amended, and complimented the fine work of the various committees. The motion was put to a vote and carried unanimously.

XIII—3. ON REPORTS OF SPECIAL COMMITTEES

W. S. Carpenter, M.D. (Wayne): Your Reference Committee on Special Committee Reports considered the reports of three committees.

XIII—3(a) *Scientific Radio Committee.* The report of the committee was approved.

XIII—3(b) *Advisory Committee to the Woman's Auxiliary.*—The Reference Committee approved the report.

XIII—3(c) *Advisory Committee to the Michigan State Medical Assistants Society.*—The report of this Committee was approved. The Reference Committee felt it was advisable that a strong Committee be maintained to give continuing advice and guidance as to future policies of the MSMAS.

W. S. Carpenter, M.D.: I move the adoption of the report of your Reference Committee as a whole.

Motion was adopted.

XIII.—4. ON CONSTITUTION AND BYLAWS

XIII—4(a). RESOLUTION RE PROCEDURE IN CASE OF VACANCY ON COUNCIL (ByLaws, Chap. 8, Sec. 10-g)

D. W. Thorup, M.D.: The Reference Committee approved this resolution, but felt that a couple of additions would make it more specific, and consequently added the words "in writing" after the words "shall be notified." It would read: **"All the component societies in the affected Councilor Districts shall be notified in writing of the vacancy."**

The Reference Committee felt that a time limit was required for the response of the county society, otherwise these could lie around for months without any action, and they specified that **response to this notification shall be forthcoming from the county society within thirty days of receipt of notification.**

The resolution was adopted as amended.

XIII—4(b). DEFERRING ACTION RE DISCIPLINE OF MEMBERS

D. W. Thorup, M.D.: This resolution is one of four related resolutions having to do with changes in the Bylaws in regard to conduct and discipline of members. I don't believe it is possible to consider this resolution alone without some comment, at least, about some of the other or at least one of the other resolutions presented.

The Reference Committee recommends the adoption of this resolution. It is felt that the proposed changes in the Bylaws with regard to conduct and discipline are very well worked out and are deserving of serious consideration, and probably ultimate adoption by this Society.

It is felt, however, that while we are basically in favor of the adoption of the changes or amendments to Chapter 6 of the Bylaws, there are minor differences

in procedures which may be due to local geographic conditions in metropolitan and rural areas, and so on, and that these differences should be ironed out.

Action on those changes and that resolution will follow.

This resolution states, "That action on these proposed amendments be deferred so that each component county society may have an opportunity to recommend such changes as will reflect its experiences and fulfill its needs."

The Reference Committee recommends the adoption of this resolution.

The report of the Reference Committee was adopted.

XIII—(4)c. APPROVAL OF M-E-G COMMITTEE RECOMMENDATIONS

D. W. Thorup, M.D.: It is the recommendation of the Reference Committee that action on Dr. Scott's resolution be deferred for one year, and that each component county society be given an opportunity to study this recommendation.

The recommendation of the Reference Committee is that each component county society refer within six months any suggestions, corrections, additions, deletions, and so on, to the Chairman of The Council, who is then to transmit them through proper channels to the House of Delegates for action at the 1957 meeting.

I so move.

The report of the Reference Committee was adopted.

XIII—4(d). STATE AND COUNTY PREROGATIVES IN DISCIPLINE OF MEMBERS

D. W. THORUP, M.D.: This resolution presented by Dr. Bailey was disapproved.

The report of the Reference Committee was approved by the House of Delegates.

XIII—4(e) MSMS APPROVAL OF COUNTY SOCIETY CONSTITUTIONAL AND BYLAWS PROVISIONS

D. W. THORUP, M.D.: The fourth resolution with regard to the Constitution and Bylaws was read. The amendments are as follows:

"Bylaws:

"Chapter 1, Section 1, which now reads, '. . . and shall in no way be inconsistent with the Constitution and Bylaws of the MSMS,' shall be changed to read, by striking out the word 'and,' '. . . which Constitution and Bylaws shall in no way be inconsistent. . . .'

"Make a new Section 2:

"The constitution and bylaws of each component county society shall receive the approval of The Council of the MSMS, the issuing of a charter being evidence of such approval. Subsequent amendments and revisions of the constitution and bylaws of the county societies shall be submitted to The Council for approval before adoption.

"Change present Section 2 to Section 3."

This resolution was considered seriously by the Reference Committee, and with the advice of legal counsel this resolution was disapproved.

Mr. Speaker, I move its disapproval.

(The motion was put to a vote and was carried, with Dr. Kasper voting "no.")

XIII—4(f). RE MEMBERSHIP IN COUNTY OF PRACTICE

D. W. THORUP, M.D.: The next resolution was presented by Dr. Scher.

The present Bylaws provide simply that a doctor may have membership in a county society other than the one in which he resides or has his office, if it is more advantageous, and with the approval of The Council.

The Reference Committee felt that the present Bylaw in this regard is sufficient, and therefore disapproves of this resolution.

Mr. Speaker, I so move.

F. P. RHOADES, M.D.: Second the motion.

The report of the Reference Committee was adopted.

XIII—4(g). CREATING HOUSE OF DELEGATES REFERENCE COMMITTEE ON NATIONAL DEFENSE AND DISASTER PRACTICE

D. W. THORUP, M.D.:

"Whereas, the Reference Committee on Emergency Medical Service, as provided for in Chapter 8, Section 10-j #13 of the Bylaws is not an accurately descriptive name for the function it is to perform; therefore, be it

"RESOLVED: That Chapter 8, Section 10-j #13 of the Bylaws be amended to read 'National Defense and Disaster Planning'."

That terminology is more in line with modern accepted and universal terminology.

Mr. Speaker, I move the adoption of this resolution.

The motion was put to a vote and was carried unanimously.

D. W. THORUP, M.D.: Mr. Speaker, I move the adoption of the report of the Reference Committee as amended.

E. C. LONG, M.D.: Second the motion.

The motion was put to a vote and was carried unanimously.

XIII—5(a) and (b). POSTGRADUATE EDUCATION AND MSMS ATTITUDE TOWARD OTHER HEALING ARTS

Vice Speaker JOHNSON: We come now to the report of the Reference Committee on Resolutions.

S. L. LOUPEE, M.D.: Your Reference Committee on Resolutions, composed of seven members, six of whom were present all through the session, took very active interest in what was going on, thoroughly discussed every point, and the work of the Reference Committee was summed up in a comparatively brief report.

However, we do not wish to imply that we want to hurry you in the adoption of anything that will be suggested here, because really we spent a lot of time discussing each and every point.

There were several resolutions pertaining more or less to the same point. One that we discussed first pertained to the question of the recognition of osteopaths within our fold—not exactly that; in fact, the resolution suggested that it be appropriate for physicians to associate with osteopaths in the matter of teaching and consultation.

Then we went on to one of the last resolutions that was introduced. The first resolution was introduced by Dr. Teed, and this resolution concerned osteopaths in Michigan. Another resolution was presented by Dr. Stroup, and that was exactly different in its provisions, but we report them both under the same portion of our report.

Action on these resolutions was postponed pending a report of the Healing Arts Study Committee, which is expected to report in 1957. We were supported in our finding by members of The Council. This portion of the Reference Committee report was adopted.

XIII—5(c). COUNCIL MINUTES TO ALL MSMS DELEGATES

S. L. LOUPEE, M.D.:

The resolution introduced by Dr. Johnson of Flint, regarding the report of meetings of The Council to members of the House of Delegates: The Reference Committee disapproved this resolution, and pointed out that facilities are now available for the dissemination of such information through the component society's Councilor, as provided in the Bylaws of the Society.

I move the adoption of this portion of the report.

H. J. MEIER, M.D.: Second.

The report of the Reference Committee was adopted.

XIII—5(d). REPORT WITHIN SEVEN DAYS OF HOUSE OF DELEGATES PROCEEDINGS

S. L. LOUPEE, M.D.: We also had a resolution by A. C. Stander, M.D., of Saginaw, regarding the distribution of copies of all resolutions and other pertinent information of each previous meeting, to be available in mimeographed form at the beginning of the next meeting. This resolution was disapproved. In its stead we have a suggestion, but it is not a requirement.

I move disapproval.

R. V. WALKER, M.D. (Saginaw): Second the motion.

The report of the Reference Committee was adopted.

XIII—5(e). CONTINUATION OF COUNCILOR CONFERENCES

S. L. LOUPEE, M.D.: The next resolution that we considered was introduced by Dr. Ryan of Kalamazoo.

The Reference Committee recommends that the House adopt this resolution.

The Report of the Reference Committee was adopted.

XIII—5(f). ESTABLISHMENT OF DEPARTMENT OF GENERAL PRACTICE IN MICHIGAN MEDICAL SCHOOLS

S. L. LOUPEE, M.D.: Next is a resolution introduced by Dr. Fenton of Wayne, regarding the establishment of Departments of General Practice in the University of Michigan and Wayne State University College of Medicine.

The Reference Committee recommends the adoption of this resolution.

The report of the Reference Committee was approved.

XIII—5(g). COMMITTEE TO STUDY USE OF THE WORD "CLINIC"

S. L. LOUPEE, M.D.: A resolution was introduced by P. S. Sloan, M.D., of Houghton-Baraga-Keweenaw County Medical Society.

The Reference Committee recommends that this resolution be adopted by the House of Delegates.

The action of the Reference Committee was adopted.

XIII—5(h). EQUAL HEALTH OPPORTUNITIES FOR ALL

S. L. LOUPEE, M.D.: Next is a resolution that the Michigan State Medical Society record itself as favoring equal health opportunities for all. This is approved by the Reference Committee.

The action of the Reference Committee was approved.

XIII—5(i). PERMANENT ADVISORY COMMITTEE ON FEES

S. L. LOUPEE, M.D.: This next resolution provides for the establishment of a permanent Advisory Committee on Fees by the Michigan State Medical Society, and that was amended to read, **"That the House of Delegates of the Michigan State Medical Society establish a permanent Advisory Committee on Fees."**

The report of the Reference Committee was adopted as amended.

S. L. LOUPEE, M.D.: Mr. Speaker, I move the adoption of the report of the Reference Committee as a whole, as amended.

This motion was adopted.

XIII—6. SPECIAL MEMBERSHIPS

D. G. PIKE, M.D.: The following names were submitted for retired and life membership and were certified by the Michigan State Medical Society as eligible for these special memberships:

(The list of names submitted for special membership was read.)

Life Membership

Berrien County: Clarence Gillette, M.D.

Genesee County: Henry Cook, M.D.

Ionia County: J. W. C. Fleming, M.D.

Kalamazoo County: U. Sherman Gregg, M.D.

Marquette County: Celestin LeGolvan, M.D., and George M. Waldie, M.D.

Muskegon County: Harry L. Clark, M.D., Marie Keilin, M.D., and Eugene S. Thornton, M.D.

Oakland County: George L. Hagman, M.D., and John K. Ormond, M.D.

Wayne County: Stilson R. Ashe, M.D.; William N. Braley, M.D.; Fritz W. Bramigk, M.D.; Bruno B. Brunke, M.D.; Peter H. Darpin, M.D.; Henri L. Gratton, M.D.; Sarkis K. Keshishian, M.D.; John C. Koch, M.D.; Alfred D. LaFerte, M.D.; Wm. W. MacGregor, M.D.; Emil V. Mayer, M.D.; Wm. R. McClure, M.D.; Carey P. McCord, M.D.; Wm. E. Miller, M.D.; Grover C. Penberthy, M.D.; Lyman J. Pinney, M.D.; Ralph W. Ridge, M.D.; Paul C. Rohde, M.D.; Jacob M. Sutherland, M.D.; and Elmer L. Whitney, M.D.

Retired Membership

Calhoun County: A. D. Sharp, M.D.

Saginaw County: Lloyd A. Campbell, M.D.

Wayne County: Ladislaus Bogusz, M.D.; Clyde H. Chase, M.D.; James C. Danforth, Sr., M.D.; Wirt A. Dawson, M.D.; Frank MacKenzie, M.D.; William D. Ryan, M.D.; and Clarence E. Weaver, M.D.

Associate Membership

Marquette-Alger County: Sara Schweinsberg, M.D.

Muskegon County: Mary Ellen Hennessey, M.D.

Washtenaw County: Malcolm A. Bagshaw, M.D.; Joseph B. Boulos, M.D.; Gerald L. Brody, M.D.; Joseph H. Chandler, M.D.; Norman E. Clarke, Jr., M.D.; Mark A. Everett, M.D.; Norman A. Fox, Jr., M.D.; Robert L. Gillett, M.D.; Glenn G. Golloway, M.D.; Jack E. Goodwin, M.D.; John T. Hayes, M.D.; Erwin P. Hoffman, M.D.; Clifford L. House, M.D.; Edwin M. Hubbard, M.D.; A. Hartwell Jewell, Jr., M.D.; J. A. Arthur Lavigne, M.D.; George E. Lewis, Jr., M.D.; John D. Lynch, M.D.; James W. Mackenzie, M.D.; Henry E. Malcolm, M.D.; Rolf F. Miller, M.D.; Robert F. Muller, M.D.; Paul Natvig, M.D.; Rudolf E. Nobel, M.D.; Leon D. Ostrander, Jr., M.D.; Warren H. Pearse, M.D.; Chrisostomo C. Santos, M.D.; Harry J. Schmidt, M.D.; Russell Scott, Jr., M.D.; Irving Shapiro, M.D.; Edwin M. Smith, M.D.; Philip R. Steinmetz, M.D.; John P. Stewart, M.D.; George R. Thompson, M.D.; Frederik S. Van Reesema, M.D.; Peter D. Vreede, M.D.; Donald J. Holmes, M.D.; Prasana K. Pati, M.D.; John B. Tisserand, M.D.; William S. Wilson, M.D.; and James A. Wood, M.D.

Wayne County: Oscar L. Barland, M.D.; Robert Borchak, M.D.; Richard A. Bruehl, M.D.; John P. Connolly, M.D.; Douglas R. Coyne, M.D.; Leonard Fox, M.D.; Maurice J. Hauser, M.D.; Loyal W. Jodar, M.D.; Benjamin Mihay, M.D.; John H. Schlemer, M.D.; Frederick L. Sperry, M.D.; Bela J. Szappanyos, M.D.; Jerome S. Weingarten, M.D.; Frank A. Weiser, M.D.; Joseph Weiss, M.D.; and Charles R. Williams, M.D.

XIII—6(a). HONORARY MEMBERSHIPS TO J. J. HERBERT AND GORDON H. SCOTT

D. G. PIKE, M.D.: By special resolution the names of Dean Gordon H. Scott and Mr. J. Joseph Herbert have been submitted to the Reference Committee on Special Memberships for honorary membership in the Michigan

State Medical Society. The Reference Committee moves that these men be granted honorary membership. I move that this report be accepted by the House of Delegates as a whole.

The report of the Reference Committee was adopted.

XIII—7. ON LEGISLATION AND PUBLIC RELATIONS

The next report is that of the Reference Committee on Legislation and Public Relations.

R. W. TEED, M.D.:

XIII—7(a). THE PRACTICE OF PSYCHOTHERAPY IN THE PRACTICE OF MEDICINE

Resolution introduced by Dr. Barker of Washtenaw County, regarding Opinion No. 2359 of Attorney General Thomas M. Kavanaugh, was approved. The Reference Committee recomemnds **that the resolution be called to the early attention of legal counsel of MSMS before copies are mailed to the Governor and to the Attorney General.**

I will read only the "Resolved" portion.

"RESOLVED: That the Michigan State Medical Society affirm its stand that the practice of psychotherapy constitutes the practice of medicine, and that Opinion No. 2359 of the Attorney General, concerning the practice of psychotherapeutics, is contrary to the public interest and should be revoked."

I move the adoption of the recommendation of the Reference Committee. The action of the Reference Committee was approved.

XIII—7(b). EXPANSION OF MEDICAL SCHOOL FACILITIES AT WAYNE STATE UNIVERSITY

R. W. TEED, M.D.: Resolution No. 13, submitted by W. S. Reveno, M.D., of Wayne County, regarding funds for the expansion of Wayne State University College of Medicine, was approved by the Reference Committee. The "Resolved" reads as follows:

"RESOLVED: That the House of Delegates of the MSMS respectfully request the Legislature of the State of Michigan to increase its appropriation to Wayne State University College of Medicine by a sufficient amount to allow the expansion."

The action of the committee was approved.

XIII—7(c). REGULATION OF AMBULANCE OPERATION

R. W. TEED, M.D.: Resolution No. 24, from Dr. Bauer of Washtenaw County, regarding hazardous operation of ambulances, was approved, with the recommendation that the resolution be referred further to the Committee on Highway Traffic Safety. I will read the "Resolved."

"RESOLVED: That the MSMS go on record as strongly urging more stringent regulation of ambulance operation by appropriate civil authorities.

The action of the Reference Committee was approved.

XIII—7(d). ADEQUATE FUNDS TO CARRY OUT CIVIL DEFENSE

R. W. TEED, M.D.: Resolution No. 26, submitted by Louis Jaffe, M.D., of Wayne County, requesting appropriation of funds by the state legislature for civil defense, was approved with the following change. The fourth "Whereas" is changed to read as follows:

"Whereas, the Commissioner of Health of the State of Michigan is the designated agent by Public Act 154 dated 1953 to direct medical planning and to integrate medical facilties in the State of Michigan in the event of enemy attack or in national disaster; therefore be it

"RESOLVED: That the Legislature of the State of Michigan be respectfully requested to appropriate annually sufficient funds to accomplish the intent of the law."

The Reference Committee therefore recommends the approval of this resolution as amended.

The action was approved as amended.

XIII—7(e). ANNUAL REGISTRATION OF M.D.'s

R. W. TEED, M.D.: Resolution No. 32, introduced by O. J. Johnson, M.D., of Bay-Arenac-Iosco County, approving the annual registration of doctors, was approved with the change of the suggested fee to $2.

After discussion, the report of the Reference Committee was not adopted.

R. W. TEED, M.D.: Mr. Chairman, I move that the report of the Reference Committee as a whole, as amended, be approved.

The Reference Committee report as amended was approved.

XIII—8. ON MEDICAL SERVICE AND PREPAYMENT INSURANCE

Next is the report of the Reference Committee on Medical Service and Prepayment Insurance.

W. S. REVENO, M.D.:

Dr. Reveno read resolution No. 3, presented by Dr. Blodgett.

XIII—8(a). MMS ANNUAL REPORT TO MSMS HOUSE OF DELEGATES

W. S. REVENO, M.D. (continuing): The Reference Committee deliberated at length on this resolution. and found that there were some confusing statements or declarations in the resolution. For instance, the statement that there is no direct liaison between Michigan Medical Service and the House of Delegates.

Taking that particular incorrect statement into consideration, the Reference Committee redrafted the resolution as presented, and submits the following:

"Whereas, the Michigan State Medical Society established Michigan Medical Service with the intention of providing medical services on a voluntary basis through a prepayment plan, and

"Whereas, the expansion of Michigan Medical Service has become a significant factor in the practice of medicine in the State of Michigan, and

"Whereas, the members of the House of Delegates of the Michigan State Medical Society usually function as the legally qualified members of the corporation of Michigan Medical Service on the second day of their annual meeting and do not have a report submitted along with the reports of other Society activities as published in the Delegates' Handbook; therefore, be it

"RESOLVED: That the annual report of Michigan Medical Service be included in the Handbook for Delegates for informative purposes."

Mr. Speaker, I move the adoption of this resolution as amended.

The substitute resolution was adopted.

XIII—8(b) & (c). COMPREHENSIVE PREPAID MEDICAL CARE PLAN (Lichter and Fryfogle) RESOLUTIONS

W. S. REVENO, M.D.: There were two resolutions, one submitted by Dr. Lichter of Wayne and another by Dr. Fryfogle of Wayne. Both resolutions dealt with comprehensive prepaid medical care plans, and some recommendations to be made for the introduction of investigations toward new types of plans.

The Reference Committee felt there was considerable overlapping in both resolutions, and reframed these two resolutions, combining them into one resolution which reads as follows:

"Whereas, it is the proper role of medicine to as-

sume leadership in determining the type and form of prepaid medical care plans, and

"Whereas, a prepaid medical care plan ideally should embody within it a sense of mutual responsibility on the part of the physician and on the part of the patient, and

"Whereas, a medical care plan should preserve the traditional right of the patient to select the physician of his own choosing; therefore, be it

"RESOLVED: That the Michigan State Medical Society approve exploration with Michigan Medical Service of a comprehensive prepaid deductible and/or co-insurance contract and also the possibility of extension of the present contract; and be it further

"RESOLVED: That the Speaker of this House of Delegates be authorized to appoint forthwith a special committee to accomplish the following:

"A. Meet with the representatives of Michigan Medical Service to study and develop details and mechanisms.

"B. Initiate, as a joint endeavor and in co-operation with Michigan Medical Service, necessary studies to ascertain what would best serve the public.

"C. Prepare a complete report for presentation to the House of Delegates at its meeting in 1957 with the proviso that copies of this report shall be sent to each member of the House of Delegates by August 15, 1957."

Mr. Speaker, I move the adoption of this amended resolution.

J. B. BLODGETT, M.D.: I second the motion.

J. E. HAUSER, M.D. (Wayne): I would like a definition of the word "comprehensive" in that resolution. Do you mean by that a comprehensive form of insurance, an over-all coverage, covering everything entirely, or is it just a modification? Could the Reference Committee have said "more comprehensive," or does it mean total coverage?

W. S. REVENO, M.D.: The interpretation is that the word "comprehensive" means "inclusive," because the resolution goes on to state as follows, in the original form: "A comprehensive prepaid medical care insurance plan to be developed with the Michigan Medical Service and implemented through a deductible and co-insurance contract."

I think that points the over-all coverage that is implied by the term "comprehensive," and points it in this particular resolution to a deductible and co-insurance contract.

E. F. FENTON, M.D.: Of course there is no such thing as "complete" coverage anywhere in the country, and I doubt if there ever will be. All these plans are of a variable degree of coverage. However, this is quite a variation from what we have had in the past. It is rather a far-reaching thing, and I think everyone should realize what it encompasses.

The present concept of the labor groups, for instance, is for complete coverage. They believe that we should have a service type of policy, such as we have with Blue Shield. This is a departure from that. This entails the spending of a portion of an individual's money for medical care as they go along, and it will cut down some of the over-utilization of the hospitals and other services that may be available.

So, I think in consideration of this matter it is something that will go far beyond anything we have now, and should be considered as such by the House of Delegates.

THE SPEAKER: The Chair would like to point out that the resolution, if voted for, merely approves the exploration of this idea together with Michigan Medical Service. Is there further discussion?

The substitute resolution was put to a vote and was carried unanimously.

XIII—8(d) & (e). URGING TOTAL PARTICIPATION OF M.D.'s IN MMS (HEIDENREICH AND BOWMAN)

W. S. REVENO, M.D.: The Reference Committee mulled over these two resolutions and came up with this resolution which we feel embodies the ideas and ideals presented in the other two:

"Whereas, there is an apparent lack of full understanding and appreciation of the basic principles and philosophy of Michigan Medical Service, and

"Whereas, the survival of the voluntary system of prepayment medical care depends on unity within this State Medical Society; therefore, be it

"RESOLVED: That the House of Delegates recommend to each county medical society that it include in its indoctrination of new members a thorough explanation of the principles, practices and objectives of Michigan Medical Service; and be it further

"RESOLVED: That this State Medical Society, its members and officers, assist each county society in its campaign to see that Michigan Medical Service continues as the most successful medically sponsored prepayment plan."

I move the adoption of this amended resolution.

R. W. TEED, M.D.: I second the motion.

The substitute resolution was adopted.

W. S. REVENO, M.D.: Mr. Speaker, I move the adoption of the entire report as amended.

L. R. LEADER, M.D.: I second the motion.

The motion was put to a vote and was carried unanimously.

C. L. WESTON, M.D. (Shiawassee): Mr. Speaker, I move we recess.

The motion was severally seconded, was put to a vote, and was carried unanimously.

The meeting adjourned at 11:30 p.m.

TUESDAY MORNING SESSION

September 25, 1956

The meeting reconvened at 9:50 a.m., J. E. Livesay, M.D., Speaker of the House of Delegates, presiding.

XIII—9. ON MISCELLANEOUS BUSINESS

E. G. M. KRIEG, M.D. (Wayne):

XIII—9(a). COMMITTEE TO STUDY MSMS FINANCIAL STRUCTURE

The first resolution for your perusal is the report of the Dues and Finance Study Committee, of which Dr. Engelke was Chairman. This report was approved after considerable discussion, with the following additions:

Your Reference Committee realized the immense amount of work contained in this report, and wishes to heartily commend Dr. Engelke and his Committee members for their excellent work.

Your Reference Committee felt that this report was of sufficient importance to recommend that a similar Committee be appointed at three-year intervals.

E. G. M. KRIEG, M.D. (continuing): Mr. Speaker, I move the adoption of the report.

R. V. WALKER, M.D.: I second it.

THE SPEAKER: Do you all understand the motion? Are you satisfied to take all these recommendations and lump them together? Are there any to which you object, which you would like to vote on individually? The recommendation is for a $5 increase in dues. There is another recommendation that a study committee be appointed every three years.

J. R. RODGER, M.D. (Northern Michigan): May I qualify that statement that a study committee be appointed every three years. Did they mean a study committee of the House?

THE SPEAKER: That is correct.

The motion was put to a vote and was carried unanimously. The report of the Reference Committee was adopted with additional recommendations.

XIII—9(b). SELECTION OF MICHIGAN'S FOREMOST FAMILY PHYSICIAN

E. G. M. KRIEG, M.D.: The next resolution has to do with the nomination of Dr. Joseph H. Sherk of Midland as Michigan's Foremost Family Physician posthumously. This was approved unanimously by your Reference Committee.

Mr. Speaker, I move the adoption of this resolution.

M. J. ITTNER, M.D.: I second the motion.

The action of the Reference Committee was put to a vote and was carried unanimously.

XIII—9(c). ESTEEM OF HOUSE OF DELEGATES FOR THE LATE J. J. HERBERT

E. G. M. KRIEG, M.D.: The resolution of sympathy to the family of Mr. J. Joseph Herbert was approved unanimously.

Mr. Speaker, I move the adoption of this resolution.

The motion was put to a vote and was carried unanimously.

XIII—9(d). APPRECIATION OF THE LATE HENRY A. LUCE, M.D.

E. G. M. KRIEG, M.D.: The resolution in regard to the passing of Dr. Henry A. Luce was approved unanimously.

Mr. Speaker, I move the approval of this resolution.

C. W. OAKES, M.D. (Huron): Second.

The motion was put to a vote and was carried unanimously.

XIII—9(e). NEW MSMS HEADQUARTERS

E. G. M. KRIEG, M.D.: Resolution No. 23, in regard to the building of a new headquarters in Lansing, was approved by your Reference Committee. I will read the "Resolved" portion of the resolution, unless you wish the whole resolution read.

"RESOLVED: That a new MSMS headquarters be built and equipped in Lansing, Michigan; and be it further

"RESOLVED: That for the building of this new headquarters the sum of $300,000 be raised by (1) the sale (at the proper time) of our present headquarters; (2) by the use of present building reserves, and (3) by the increasing of dues in the amount of $5 per year, beginning in the 1957 fiscal year, said increase in dues to be used only for the purpose of defraying the cost of building and equipping a new MSMS headquarters."

Mr. Speaker, I move the adoption of this resolution.

The motion was put to a vote and was carried unanimously.

The action of the Reference Committee was approved.

E. G. M. KRIEG, M.D.: Mr. Speaker, I move that the report of the Reference Committee be adopted as a whole.

H. J. MEIER, M.D.: I second the motion.

The motion was put to a vote and was carried unanimously.

X—39. PLAN FOR EXPEDITING WORK OF THE HOUSE OF DELEGATES

A. C. STANDER, M.D.: Mr. Speaker, I would like to preface this resolution with a few lines from Eddie Guest's poem, and perhaps dedicate it to Dr. Foster:

"Somebody said it couldn't be done;
But he, with a chuckle, replied
That maybe it couldn't,
But he'd be the one
Who wouldn't say so 'til he tried.

"So he buckled right in
With a bit of a grin,
And before you knew it, he'd done it!"

"Whereas, a great amount of time is wasted in each session of the House of Delegates due to the confusion created by the inability of the delegates to comprehend the full meaning of the oral reading of resolutions; therefore, be it

"RESOLVED: That one or more of several procedures be considered and put in effect, as follows:

"1. That the time of resolutions be moved ahead sufficiently to allow either the mimeographing of sufficient copies of the resolution to be furnished to delegates;

"2. Or, the preparation of slides to be projected on a screen during the reading of the reports of the reference committees;

"3. Or, the direct reflection type of screen projector;

"4. Or, any such method that may be devised to carry through the intent and purpose of this resolution."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

X—35. COMMITTEE TO STUDY USE OF EXCESS BEDS IN TUBERCULOSIS SANATORIA

W. C. BEETS, M.D. (Kent):

"Whereas, it is evident that there is a continuing decline in the tuberculosis hospitalization requirements in the State of Michigan, and

"Whereas, this has resulted in an excess of beds in tuberculosis sanatoria in practically all areas of the state except the southeastern section, and

"Whereas, there is a tendency at present to utilize these beds for diagnosis and treatment of conditions other than tuberculosis; therefore, be it

"RESOLVED: That the MSMS appoint its own committee to study the problem and to make recommendations for the proper utilization of such excess beds for the public good."

This was referred to the Reference Committee on Hygiene and Public Health.

X—36. MSMS REPRESENTATIVE ON COMMITTEE FOR DRAFTING UNIFORM AUTOPSY CODE

S. E. GOULD, M.D. (Wayne):

"Whereas, the performance of autopsies is of importance in the advancement of medical science and in promoting the welfare and the protection of the public, and

"Whereas, the autopsy is performed in the hospital as a public service, and

"Whereas, problems of an administrative or professional nature occasionally arise in connection with the autopsy as they pertain to funeral directors, and

"Whereas, the Michigan Funeral Directors Association has made it known that it would like to meet with representatives of the Michigan Pathological Society and the Michigan Hospital Association and the Michigan State Medical Society to discuss mutual problems and draw up a code of procedures pertaining to autopsies; therefore, be it

"RESOLVED: That The Council of the Michigan State Medical Society be authorized to appoint a member of the Section on Pathology to represent the Society on a commitee having a representative from the Michigan Hospital Association, the Michigan Pathological Society and the Michigan Funeral Directors Association, to draw up such a code for presentation to The Council for its consideration."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions. (See amendment, page 1540.)

X—37. (MOTION) INFORMATION FROM AMA DELEGATES

R. H. PINO, M.D.: Mr. Speaker, I would like to introduce the following motion. I understand discussion of the motion may be in order when it comes back to the House.

"That through the Department of Public Relations of the Michigan State Medical Society, and at the discretion of The Council, our delegates to the American Medical Association provide material to the members of this House of Delegates indicating the proposals they hope to sponsor in the succeeding annual meeting of the AMA House of Delegates, including national plans.

"That this material be provided to the delegates of the Michigan State Medical Society at least three months in advance of the annual AMA meeting, and that the members of the Michigan State Medical Society House of Delegates furnish to our AMA delegates every possible aid we can to help them and let them know of our thinking."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

XIII—10. REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL

E. A. OSIUS, M.D.: Mr. Speaker and Fellow Colleagues:

This delayed appearance is not a staged process, I can assure you. If any of you have any illusions about The Council not doing any work, or the executive office not earning their salaries, I recommend to you a position on the Reference Committee on Reports of The Council, which will immediately disillusion you on that subject.

We have quite a lengthy report, which we took up item by item from the Handbook and the supplementary report of The Council which was read to you yesterday.

The Reference Committee reviewed in detail the reports of The Council, which reflected the tremendous amount of work by The Council and its committees during the past year. This represented a total of fourteen eight-hour days, not counting the time spent in coming and going to the meetings.

A total of 1,056 items were studied as well as the reports of The Council's twenty-nine committees and the Society's nineteen committees.

Membership: We note with pleasure the growth in membership to 6,157.

Finance: The Reference Committee approves the financial work of The Council. The financial report, together with the report of Dr. Engelke's Committee to Study MSMS Financial Structure, assures us that the finances are in good hands and are being ably administered.

THE JOURNAL: The JOURNAL continues to be outstanding among state society journals, and with all this is also able to show a positive balance. The editor, Dr. Wilfrid Haughey, is as usual to be congratulated.

Organization: A review of the chapter on organization reveals the wide-awake and forward-looking attitude of the Michigan State Medical Society to which we are accustomed. The annual county secretaries' meeting over a period of three days; the Tenth Michigan Clinical Institute; the meetings of the delegates to the American Medical Association; the Residents-Interns-Medical Students Conference; the Ninetieth MSMS Annual Session in Grand Rapids; the imposing list of national societies headed by Michigan doctors, and last, but not least, the modern handling of the MSMS membership records by the installation of the IBM machines in the Lansing office, are commended.

The installation of these machines is, of course, to enhance the business details, management, and the collection of vast amounts of information that are being constantly requested by other organizations from the Michigan State Medical Society.

It is intended that the billing for dues can be expeditiously handled in this fashion, along with other benefits. Some of the Reference Committee felt that the billing by the state office might deprive the county societies of some autonomy. However, the majority voted approval of recommendation No. 1, page 81, abolishing the 1 per cent collection credit which is now being granted the county societies for collection of dues.

The Reference Committee believes that the Society should feel indebted to President Jones for the many hours he has spent in visiting personally the many county societies, and we extend to him herewith our sincere thanks for the excellent example that he has set.

C. I. OWEN, M.D. (Wayne): I move that each county society decide for itself whether or not the state shall send the bill for the dues, and that that be the method followed.

F. P. RHOADES, M.D.: I support the motion.

R. W. TEED, M.D.: Mr. Speaker, I think it is obvious that the point hinges on the 1 per cent.

Therefore, I would offer a substitute motion, to the effect that the recommendation of The Council on this matter be accepted, except that the 1 per cent be not eliminated.

A. C. STANDER, M.D.: I second that motion.

THE SPEAKER: All those in favor will say "aye"; opposed, "no." The motion is carried.

E. A. OSIUS, M.D.: *Public Relations.*—The Committee views with gratification the continuing excellent work of the Public Relations Committee, noting particularly the establishment of a public relations library at the headquarters in Lansing, as well as the many hours spent maintaining our contacts with the Legislature, industry, and the public at large, both metropolitan and rural. We are convinced that our public relations department is an outstanding one, of which we may be proud.

Woman's Auxiliary.—The report of the Woman's Auxiliary was approved. The unusual activities and the excellence of the achievements indicate that this aspect of the Society's activities is in good hands. We look forward to next year with anticipation.

Contact with Government Agencies.—Perusal of the paragraph on contact with governmental agencies reassures us that these desirable contacts are being assiduously maintained. The Reference Committee recommends that the sending of representatives of MSMS to Washington on Michigan Day be continued. A good beginning has been made with liaison with the Governor's office, which should be continued and improved.

We welcome the co-operation of the new Secretary of the State Board of Registration in Medicine, Dr. E. C. Swanson of Vassar, and the Commissioner of Health, Dr. A. E. Heustis.

Home medical care for veterans has been continued through the efforts of our officers, thereby maintaining a good relationship with the many veterans residing in this State who need or may need medical care. Many other valuable contacts were also reported, such as the University of Michigan, Wayne State University College of Medicine, Michigan Crippled Children Commission, et cetera.

Contacts with Voluntary Agencies and Organizations.—An excellent example of good public relations is found in the chapter on contacts with voluntary agencies and organizations. The full page advertisement regarding the controversy over Blue Shield and Blue Cross, closer liaison with the State Bar Association, the Operating Room Supervisors Conference, the Medical Assistants Society, and many others, are approved most heartily.

Beaumont Memorial.—The report of The Council on this matter is fully approved. The Reference Committee wishes to call the attention of the delegates to the fact

that there is still a $9,000 deficit outstanding on the building, and that less than 50 per cent of the MSMS members have contributed to this Beaumont Memorial. Not only does this deficit have to be met, but further expenditures for the interior furnishings, the collection of historic specimens and the maintenance of the building and its contacts must be provided for. The Reference Committee agrees with The Council that the possible establishment of a Beaumont Memorial Foundation, with annual dues-paying members, and possibly some help from our Public Relations Department funds might be a solution to this question.

C. J. BAILEY, M.D.: I move that a subscription card be sent to those who have not contributed to the Beaumont fund.

F. P. RHOADES, M.D.: I second the motion.

The motion was put to a vote and was carried unanimously.

H. F. FALLS, M.D.: I would like to recommend to the Beaumont Memorial Committee that they contact the tourist agencies on Mackinac Island and arrange that they mention a sentence or two about the availability of this facility to the public.

I so move.

S. E. GOULD, M.D.: I second the motion.

THE SPEAKER: I will ask for a show of hands. All in favor, raise your hand. Opposed. The motion is lost.

Committees.—A total of eighty-eight meetings of the various committees of the State Medical Society and of The Council were held during the past year. These committees are the backbone and the sign of progress for this Society. Particularly active during the past year were many committees such as Child Welfare, Health and Accident Insurance Policy Control, Rural Medical Service, and many others.

We wish to call attention to the Arbitration Committee which deals with the Uniform Fee Schedule for Governmental Agencies. This fee schedule has not been revised since December 1949, and it is the Reference Committee's opinion that the Committee on Study of Uniform Fee Schedule for Governmental Agencies should be reactivated and the Uniform Fee Schedule for Governmental Agencies should be restudied and revised forthwith.

Annual Reports of Committees of the Council.—The Reference Committee approves the reports of the entire group of committees of The Council, but wishes to comment on a certain few.

One of these is the Committee on Courses on Medical Economics and Ethics, which has done an outstanding piece of work in arranging a large series of lectures to medical students at the University of Michigan. We believe this is an important early contact with young prospective doctors which will place before them some of the socio-economic problems that the medical profession has to solve and is solving. It is a picture painted by actual practicing physicians on the battle-front, and is the type of information which is usually not obtained from a medical school curriculum.

The Reference Committee feels that this good work should continue and be extended even conceivably to other groups of students, possibly even prospective or premedical students. The caliber of men presenting these talks is to be commended, and the time spent by Dr. Teed in arranging this entire course is deeply appreciated by this Reference Committee and, I am sure, by the State Society and its officers.

We also call to your attention the report of the Hospital Relations Committee, which we believe should be called to the attention of every county society; and we call particularly to your attention paragraph 4, page 68, printed in capitalized letters.

The Committee on the Study of Prevention of Highway Accidents is continuing its excellent work in a subject of great public need and interest. We trust that this Committee will continue to expand and to explore new avenues with the idea of promoting greater safety to our citizens while on the road.

We approve the report of the Committee on Study of the Basic Science Act, and commend it for its work, at the same time recalling the large amount of groundwork which previous Committees carried out so well, and to whom some of this credit must go also. The Committee should be continued in order to keep in touch with changing conditions, and the status of the Act and its effect on the profession of this State should be constantly reviewed and surveyed.

F. L. TROOST, M.D.: I am sure this session would not be complete without my speaking about the basic science law, although I did not do so last year.

I think the House of Delegates should be apprised of the fact that the changes in the basic science law, as written on page 71 of the Handbook, were not the work of any committee of the Michigan State Medical Society. These changes were brought about over the objections of the State Society through its Basic Science Study Committee, legal counsel and public relations men. It was brought about by a group of doctors in Ingham County, by Dr. Coller, Dr. Masters, Dr. Cawley of Jackson, and others.

As far as our group is concerned, we are well satisfied to let the law stand as it is now, and to offer no further suggestions or amendments until this law has had a chance.

It has accomplished this much: Instead of having three states whose people could come in without basic science examination, we now have twenty-four states, and the list is expanding each day. That is due to a provision in the law that any official examining body in the United States, like any state board of registration, may now have their examination in basic science accepted by the basic science board without further examination. It has resulted in a great many more basic science certificates being issued without examination.

E. A. OSIUS, M.D.: Another committee which carried on a large amount of work was the Study Committee on Fee Schedules for Michigan Medical Service. This Committee was first assigned to draft a fee schedule for a $6,000 Michigan Medical Service family income service contract. To this was later added consideration of a resolution presented in the House of Delegates in September 1955, on the subject of division of fees, and to this also a re-study of the $5,000 and $2,500 contracts.

To refresh your minds, the resolution requesting the division of fees was as follows:

"RESOLVED: That the President of the Michigan State Medical Society appoint a committee to formulate this procedure (the division of fees), and when the methods are approved by The Council of the Michigan State Medical Society, that they be transmitted to Michigan Medical Service to be made effective; and be it further

"RESOLVED: That due consideration shall be given to the ethical, legal and administrative and other phases involved."

The Committee, with three dissenting votes, recommended that "Whenever more than one doctor of medicine actively and personally participates in any medical treatment of or surgical procedure on a patient for which a single fee is payable by Michigan Medical Service, the doctor in charge of such care shall specify in writing the portion of such fee which has been earned by the assisting or consulting doctors, and inform Michigan Medical Service of the amount thereof. Thereupon, the Michigan Medical Service shall be authorized to allocate and pay the respective portion of the scheduled fee directly to the participating doctors in accordance with such direction."

A careful review by the attorneys for Michigan Medical Service and the State Society's legal counsel has disclosed that this is illegal and unethical, and upon advice by counsel is not in accord with the Judicial Act of the AMA; whereupon, another meeting was

held and, as outlined in the Supplemental Report of The Council, the following resolution was adopted and passed by this Committee:

"Whereas, this Committee has given consideration to various programs or procedures for the accomplishment of the objectives of the resolution of the House of Delegates adopted September 26, 1955, re division of fees, and

"Whereas, this Committee has been charged with responsibility thereby for 'due consideration' of 'ethical, legal, and administrative and other phases involved,' and *has given* due consideration thereto; therefore, be it

"RESOLVED: That the Committee reports to The Council as follows:

"1. The Committee finds it impossible to determine a method of division of its scheduled fees for physicians by Michigan Medical Service as requested, which would be ethical, legal and administratively feasible and conform to opinions of the Judicial Council of the American Medical Association on the subject.

"2. However, the Committee recommends that The Council request Michigan Medical Service to consider the inclusion in its subscribers' certificates of a benefit for the services of assistants in certain defined cases, and payment for such services directly to the assistant."

The $6,000 fee schedule has been studied and prepared by this Committee, but is at present in the hands of The Council for further study. The $5,000 fee schedule was also studied, and it was decided that this should be five-sixths of the established $6,000 fee schedule. It was decided that this was to be arrived at the nearest $5 unless the said fee was lower than the $2,500 lower income group fee schedule. It was felt by this Committee that the $2,500 fee schedule should not be changed. Much actuarial work remains to be done, as a study of this type is long and complicated and has many hidden pitfalls and angles.

Matters Referred to the Council by the 1955 House of Delegates.—The Reference Committee approves the report of The Council in regard to these matters outlined on pages 78, 79, 80 and 81 of the Handbook, among which are included: Cancer quackery; possible optometric legislation; pollution of inland waterways; screening of foreign interns; periodic health examinations by hospital staffs; examination of the mentally ill, and others.

Item 11 regarding surgical fees has been covered elsewhere.

E. A. Osius, M.D.: If I seem to read too rapidly, Dr. Johnson, I am sorry. I didn't intend to.

Recommendations.—Recommendations Nos. 1, 2, 3, 6, 7, 8 and 9 are approved by this Reference Committee. Some of these have been covered by resolutions already introduced into the House. In regard to No. 4, the Reference Committee recommends that the House of Delegates instruct The Council to study and revise as necessary the Uniform Fee Schedule for Governmental Agencies forthwith.

We call particular attention to No. 8(b) which would require an amendment to the Bylaws, and the Reference Committee recommends the adoption of No. 8(b).

Supplemental Report of The Council.—This report was read to the delegates by the Chairman of The Council, Dr. Bruce Wiley, yesterday, and the Reference Committee approves items Nos. 1, 2, 3, 4, 5, 6, 7 and 8. Item No. 9, the poll on social security, is inconclusive and hence no opinion can be rendered.

Item No. 10, which deals with medical care for military dependents, is approved in its basic tenets. The Reference Committee approves The Council's firm stand regarding the Governor's Study Commission on Prepaid Hospital Care Plans.

Item No. 12: This paragraph deals with the future expansion of the Michigan State Medical Society as regards a new building to enhance the professional and business efficiency of the administrative staff, and it is the Reference Committee's opinion that this is a necessary and important step which should be consummated as soon as possible, but with careful consideration and every possible foresight to take care of possible future contingencies. We recall to your minds a resolution already presented on this floor in regard to a building fund.

Item No. 13: The Reference Committee approves the report of the Liaison Committee with Michigan Hospital Service, as well as item No. 14 dealing with the placement of physicians throughout the State.

Item No. 15 has been dealt with elsewhere.

Item No. 16: Annual Reports of Committees of The Council. Six additional reports were submitted to The Council, and these were considered by the Reference Committee, selecting the salient and important features of each one for comment.

We approved the recommendation of The Council that the position of Executive Secretary of the State Board of Registration in Medicine be a full-time position with an adequate salary, and respectfully request such action in proper form from the Legislature. The Reference Committee also approved the conservative action of The Council on the report of the Healing Arts Study Committee. The report of the Committee on Closed Panel Practice has been covered in a resolution presented to the House.

In a supplementary report on Michigan Medical Service, several problems were presented, which are still under study and not yet ready for presentation.

The Reference Committee commends the report of the Liaison Committee with the Michigan Social Welfare Department, and recommends that it receive attention by each county society as published in The Journal of MSMS.

The Committee on Rural Medical Service has reported on many activities, including the medical school deans' panel, M.D. Placement program, federal funds for health centers, subsidizing home nursing plans in rural areas, scholarship funds for medical students, et cetera. Several other items still require further study.

The meeting was adjourned at 2:30 a.m.

Mr. Speaker, I move the adoption of this report as a whole, as amended.

W. W. Babcock, M.D.: Second the motion.

A. C. Stander (Saginaw): I would like to move that not only does MMS consider the establishment of an assistant's fee, but also that they reconsider the possibilities of the division of fees.

The Speaker: You are moving an addition to the motion of the Fee Study Committee. Would you like that read again? "However, the Committee recommends that The Council request Michigan Medical Service to consider the inclusion in its subscribers' certificates of a benefit for the services of assistants in certain defined cases, and payment for such services directly to the assistant."

The motion is to include the additional language that they also reconsider the possibility of division of their fees for assistants.

Is there a second?

O. J. Johnson: I second that.

The Speaker: All those in favor will say "aye"; opposed, "no." The motion is lost.

Now we are back to the motion to approve the report of the Reference Committee as amended.

The motion was put to a vote and was carried unanimously.

X—38. APPRECIATION TO HARVEY V. HIGLEY, VA ADMINISTRATOR

D. R. Smith, M.D.: This is a resolution of appreciation to Harvey V. Higley, Administrator of Veterans' Affairs.

"Whereas, the Hometown Care for Veterans Plans of the Veterans Administration was originally developed with the assistance of the Michigan State Medical Society and Michigan Medical Service, and

"Whereas, this program was placed in jeopardy by the projected action of a department of the Veterans Administration, and

"Whereas, the personal intervention of Mr. Higley resulted in the maintenance of the present program in Michigan; therefore, be it

"RESOLVED: That this House of Delegates express its appreciation to Mr. Harvey V. Higley, Administrator of Veterans' Affairs, for his prompt and meritorious action."

This was referred to the Reference Committee on Legislation and Public Relations.

C. I. OWEN, M.D.: I move that we recess.

The motion was severally seconded, was put to a vote, and was carried unanimously.

(The meeting was recessed at 11:45 a.m.)

TUESDAY EVENING SESSION

September 25, 1956

The final session convened at 8:15 p.m., J. E. Livesay, M.D., Speaker of the House of Delegates, presiding.

XIII—7(e). ANNUAL REGISTRATION OF M.D.'s (Reconsideration)

O. K. ENGLEKE, M.D. (Washtenaw):

I would like to move that the vote on the resolution re Annual Registration of M.D.'s be considered at this time.

R. W. TEED, M.D.: Second the motion.

The motion is lost by a vote of 32 "yes" and 50 "no."

The action that was taken previously will stand.

(Vice Speaker Johnson assumed the Chair.)

VICE SPEAKER JOHNSON: We will consider supplementary reports of reference committees at this time.

XIII—5(j). SUBMISSION OF HOUSE OF DELEGATES RESOLUTIONS IN ADVANCE

S. L. LOUPEE, M.D.:

The Reference Committee reports on resolution No. 34, introduced by Dr. O. J. Johnson, as follows:

The above resolution as presented was disapproved by the Reference Committee, although the Committee highly endorses the sentiments expressed therein and recommends that The Council give full consideration to the problem presented. It is our hope that The Council will be able to provide the delegates with copies of a majority of the resolutions before or at the opening of the 1957 session.

I move the adoption of this report, Mr. Chairman.

CHAIRMAN JOHNSON: The motion is to disapprove the resolution. Is there a second?

E. G. M. KRIEG, M.D.: I second the motion.

CHAIRMAN JOHNSON: Now we will vote on the motion to adopt the report of the Reference Committee, which is to disapprove this resolution.

The motion was put to a vote and was carried unanimously.

XIII—5(k). MEDICAL CLASSES AT UNIVERSITY OF MICHIGAN AND WAYNE STATE UNIVERSITY TO SEND REPRESENTATIVES TO HOUSE OF DELEGATES SESSION

S. L. LOUPEE, M.D.: The next resolution in order is No. 35, presented by Dr. Falls.

"Whereas, it is the avowed policy of the Michigan State Medical Society to disseminate information, to present and future physicians, pertaining to medical economics, medico-legal and other aspects of medicine, and

"Whereas, the orientation of medical students in such subjects is a highly desired objective of this policy; be it, therefore,

"RESOLVED: That the House of Delegates invite each junior and senior medical class of Wayne State and the University of Michigan to elect three delegates to attend the House of Delegates session, and that these representatives serve without vote but participate fully in all the functions of this organization; and be it further

"RESOLVED: That the expenses of such delegates be defrayed by the Michigan State Medical Society."

I move the adoption of this resolution.

R. W. TEED, M.D.: Second the motion.

Approved as amended.

XIII—5(l). PLAN FOR EXPEDITING WORK OF HOUSE OF DELEGATES

S. L. LOUPEE, M.D.:

Resolution No. 36 was introduced by Dr. Stander. This resolution was disapproved because action on similar proposals has been taken previously by this Reference Committee.

(Dr. Loupee read resolution No. 36, submitted by Dr. A. C. Stander.)

J. M. WELLMAN, M.D.: May I speak to the problem before the House at the present time? I am a member of this Reference Committee. As I recall the resolution introduced by Dr. Stander this morning, calling for the various alternatives in which material contained in resolutions presented to this House of Delegates was disapproved, the Reference Committee recommended that there was enough merit in having this material available. Recognizing that it is an administrative problem, the Reference Committee recommended that The Council investigate methods by which material contained in resolutions could be presented to this House of Delegates for consideration and report back next year.

CHAIRMAN JOHNSON: I would be very happy to accept that as a motion, Dr. Wellman, if you will make it in that fashion.

J. M. WELLMAN, M.D.: I so move.

S. L. LOUPEE, M.D.: I second it.

The motion was put to a vote and was carried unanimously.

XIII—5(m). MSMS REPRESENTATIVES ON COMMITTEE DRAFTING UNIFORM AUTOPSY CODE

S. L. LOUPEE, M.D.: The Reference Committee reports as follows on resolution No. 38.

This resolution was approved by the Reference Committee in principle, but a change in wording is proposed as an amendment to this resolution, namely:

"RESOLVED: That The Council of the Michigan State Medical Society be authorized to appoint two members of the State Medical Society, one a family physician and one a member of the Section on Pathology, to represent the Society on a committee consisting of a representative from the Michigan Hospital Association, the Michigan Pathological Society and the Michigan Funeral Directors Association, to draw up such a code for presentation to The Council for its consideration."

I offer this and move its adoption.

W. S. REVENO, M.D.: Second the motion.

The motion was put to a vote and was carried unanimously.

Approved as amended.

XIII—5(n). INFORMATION FROM AMA DELEGATES

S. L. LOUPEE, M.D.: The Reference Committee revamped the motion and presents it in this form for your consideration:

This motion as written was disapproved, but your Reference Committee is in sympathy with its sentiments, and wishes to recommend that the report of the delegates to the AMA, presented at the annual session of the MSMS House of Delegates, be submitted in two parts: (1) A summarization of the past year's activities; (2) a summarization of their proposals, to be submitted for consideration at the next general session of the House of Delegates of the AMA."

Mr. Chairman, I move the adoption of the Reference Committee's report.

R. F. FENTON, M.D.: Second the motion.

R. L. NOVY, M.D.: I move that this motion be tabled.

E. G. M. KRIEG, M.D.: I second that.

(The motion to table was put to a vote and was carried unanimously.)

XIII—5(o). APPRECIATION TO HARVEY V. HIGLEY

S. L. LOUPEE, M.D.: We have one more resolution, No. 40, introduced by Dr. Smith. Mr. Chairman, I move the adoption of this resolution.

E. G. M. KRIEG, M.D.: Second.

The motion was put to a vote and was carried unanimously.

The action of the Reference Committee was approved.

S. L. LOUPEE, M.D.: Mr. Chairman, I move the adoption of the report of the Reference Committee on Resolutions, including everything that was adopted piecemeal yesterday and today.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

(The Speaker resumed the Chair.)

XIII—11. COMMITTEE TO STUDY USE OF EXCESS BEDS IN TUBERCULOSIS SANATORIA

THE SPEAKER: *Report from the Reference Committee on Hygiene and Public Health.* Dr. Molner.

J. G. MOLNER, M.D.: There is a time when simplicity arrives, and I think this is that time.

This resolution was introduced by Dr. W. C. Beets of Kent County and was referred to our Reference Committee. Participants in this resolution were all invited to attend our meeting, and are in accord with our finding.

(Dr. Molner read resolution No. 37, submitted by Dr. Beets.)

J. G. MOLNER, M.D.: I move the adoption of this resolution, Mr. Speaker.

E. G. M. KRIEG, M.D.: Second the motion.

The motion was put to a vote and was carried unanimously.

XIV—ELECTIONS

XIV—1. COUNCILOR, 1ST DISTRICT

A. E. Schiller, M.D., of Detroit, is the incumbent.

J. G. BIELAWSKI, M.D. (Wayne): Mr. Speaker, I move the nomination of Dr. Schiller of Detroit.

THE SPEAKER: Dr. Schiller has been nominated to succeed himself. Are there other nominations?

E. H. LAUPPE, M.D. (Wayne): I second the nomination of Dr. Schiller.

J. G. BIELAWSKI, M.D.: I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Dr. Schiller.

This motion was seconded and was carried unanimously.

THE SPEAKER: Dr. Schiller is re-elected.

XIV—2. COUNCILOR, 4TH DISTRICT

Nominations are in order for Councilor from the 4th District. Ralph W. Shook, M.D., Kalamazoo, incumbent.

S. L. LOUPEE, M.D.: Mr. Speaker and members of the House, it is my pleasure and privilege to nominate as Councilor from the 4th District Ralph W. Shook, M.D., of Kalamazoo, who has very ably filled that position for the last several years and who has even visited the component societies frequently and co-operated with us in making our agencies operate well.

D. W. THORUP, M.D.: I second the nomination.

F. C. RYAN, M.D.: I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot. This motion was seconded and carried unanimously.

THE SPEAKER: Dr. Shook is re-elected.

XIV—3. COUNCILOR, 5th DISTRICT

The floor is now open for nominations for Councilor from the 5th District. J. D. Miller, M.D., incumbent.

R. E. RICE, M.D.: Mr. Speaker, as J. D. Miller will not be continuing as Councilor, it is my privilege to nominate Dr. C. Allen Payne of Grand Rapids, Kent County.

Dr. Payne was born in Laurium, Michigan, in March, 1909. He took his premedical training at Hahneman College of Science, receiving his B.S. degree in 1931. He attended the Hahneman Medical College in Philadelphia, receiving his M.D. degree in 1933. He then interned in the Miami Valley Hospital, Dayton, Ohio, 1933-34.

He was a resident in pathology at Methodist Hospital, Indianapolis, in 1934-36, and at the Henry Ford Hospital, Detroit, in 1936-38, receiving his M.S. in pathology in 1938 from the Wayne State University, Detroit.

He has been the pathologist at Blodgett Hospital, Grand Rapids, since 1938. This was interrupted by military service from 1942 to 1946, when he was the pathologist for the Harper Hospital Unit, U. S. Army in the European theater.

He is a past president of the Kent County Medical Society, present chairman of the Michigan Cancer Coordinating Committee, past president of the Michigan Pathological Society, and represents the American Pathological Society in Michigan. He is a member of the founding committee of the Michigan Association of Blood Banks, and conducted mass blood typing for the Kent County Medical Society.

He is the author of a number of professional articles.

For the past four years he has been chairman of the MSMS Public Relations Committee. He has done an outstanding job in this field throughout the state, and has provided leadership in numerous county secretary and public relations conferences. His participation in these activities has resulted in a valuable understanding of the workings of our State Society.

Mr. Speaker, it is my distinct privilege to nominate C. Allen Payne, M.D., for Councilor of the Fifth District.

K. E. FELLOWS, M.D. (Kent): I second the nomination.

PAUL IVKOVICH, M.D.: I move that nominations be closed and that the Secretary cast the unanimous vote. The motion was seconded and carried unanimously.

THE SPEAKER: Dr. Payne is elected.

XIV—4. COUNCILOR, 6TH DISTRICT

The floor is now open for nominations for Councilor from the 6th District. H. H. Hiscock, M.D., of Flint, incumbent.

C. W. COLWELL, M.D. (Genesee): I would like to nominate Dr. Hiscock to succeed himself.

O. J. JOHNSON, M.D.: I would like to second the nomination of Dr. Hiscock.

E. C. TEXTER, M.D.: I move that nominations be closed and that the Secretary cast the unanimous ballot for Dr. Hiscock.

The motion was severally seconded, was put to a vote, and was carried unanimously.

THE SPEAKER: Dr. Hiscock is re-elected.

XIV—5. DELEGATES TO AMA

THE SPEAKER: Next is the election of delegates to the AMA. There are three incumbents, and three to be elected. They are W. D. Barrett, M.D., Detroit; W. H. Huron, M.D., Iron Mountain, and R. L. Novy, Detroit.

W. L. BROSIUS, M.D. (Wayne): Mr. Speaker and members of the House, we have had considerable discussion about our delegates to the AMA. I am not going to bore you at this late hour with a burst of oratory, but I think something should definitely be pointed out.

Our delegates to the AMA should be men who would represent this group in their business, in their deliberations, for the furtherance of the good of medicine in Michigan and in general.

I would like to place in nomination the name of a man who does know his way around. He has had experience which he has gained on the ground. We all trust him. We all like him. He is a personal friend.

I nominate Wyman D. Barrett.

J. E. CROUSHORE, M.D. (Wayne): I would like to second Dr. Brosius' nomination of Dr. Barrett as delegate to the AMA.

W. S. REVENO, M.D.: I would like to place in nomination the name of Dr. R. L. Novy of Detroit, present incumbent, to the House of Delegates of the AMA.

L. J. BAILEY, M.D.: It is redundant to speak about Dr. Novy's qualities, but I should like to second his nomination.

D. R. SMITH, M.D.: I would like to nominate Dr. W. H. Huron. Dr. Huron has been a delegate to the AMA for eight years, and is the present incumbent.

J. M. WELLMAN, M.D.: Mr. Speaker, I would like to second the nomination of Dr. Huron as delegate to the AMA.

W. L. BROSIUS, M.D.: I move that nominations be closed and that the Secretary cast the unanimous ballot for all three incumbents.

The motion was seconded, put to a vote and was carried unanimously.

THE SPEAKER: These three delegates are elected by acclamation.

XIV—6. ALTERNATE DELEGATES TO AMA

THE SPEAKER: The next item of business is the election of alternate delegates to the AMA. The incumbents are G. W. Slagle of Battle Creek, William Bromme of Detroit, and J. R. Rodger of Bellaire.

H. C. HANSEN, M.D. (Calhoun): It gives me great pleasure to nominate Dr. George W. Slagle to succeed himself, as alternate delegate.

J. P. MARKEY, M.D. (Saginaw): I second the nomination.

C. I. OWEN, M.D.: It gives me pleasure to nominate Dr. William Bromme for alternate delegate, to succeed himself. He is well known to all of us, and he is recommended by the Wayne delegation.

E. G. M. KRIEG, M.D.: Mr. Speaker, I am pleased to second that nomination.

O. J. JOHNSON, M.D.: I would like to place in nomination the incumbent, John R. Rodger.

FRANK IVKOVICH, M.D.: I second the nomination.

E. G. M. KRIEG, M.D.: I move that nominations be closed.

The motion was seconded, put to a vote and was carried unanimously.

Subsequently, the Speaker announced (after the balloting) that Alternate Delegates were elected in the following order of seniority: One, Dr. Bromme; two, Dr. Rodger; three, Dr. Slagle.

XIV—7. PRESIDENT-ELECT

THE SPEAKER: The next item of business is the election of a President-elect.

J. R. RODGER, M.D.: Mr. Speaker, we in this House know that the top responsibility for the business of this State Society is not handled by just one man but is shared by a group of men. However, the public does not realize this, and in the eyes of the public the man who happens to be President of the Michigan State Medical Society is Mr. Michigan State Medical Society as far as they are concerned.

Therefore, in selecting a President I think it behooves us to occasionally select one of the younger age group to demonstrate to the public that we have younger leadership as well as older leadership in our Society. We must do this in relation to selecting a man who cannot only do that before the public, but who can also ably represent us in the responsibilities he must have as President.

Therefore, we look back over the history of the Society and find that in the past we have done just that. If we look over the list of our Past Presidents it is interesting to note that two of the men who were Presidents of this Society in the 1920s are still alive and still going strong, and four of the men who were Presidents of this Society in the 1930s are still alive and some are still going strong. One of them sat in this session yesterday and today. Those men must have been young men when they were President of the Michigan State Medical Society.

Therefore, I would like to place in nomination the name of a man who is in this younger age group, a man who I feel sure can not only represent our interests in the office of President, but in the eyes of the public, one who will demonstrate that we have younger as well as older leadership.

I would like to present the name of a man who has been a member of this House, who has been a member of The Council since 1950, who has been on the Board of Michigan Medical Service since 1953, and who at the present time is on the Executive Committee of Michigan Medical Service.

I am proud to present to this body the name of George W. Slagle, M.D., of Battle Creek, as President-elect.

J. P. MARKEY, M.D.: Mr. Speaker and members of the House of Delegates, it is my pleasure to present in nomination the name of a man who has been a member of the House of Delegates for many years and who has served on The Council for eight years.

He is a Past President of his County Medical Society. He is a quiet, pleasant gentleman, who will place a hand on your shoulder, whether you are a young or an old practitioner of medicine, and who will counsel with you.

I nominate Lloyd C. Harvie, M.D., of Saginaw.

FRANK IVKOVICH, M.D.: I move that nominations be closed.

The motion was seconded, put to a vote and was carried unanimously.

Subsequently, the Speaker announced (after the balloting) that Dr. George W. Slagle was elected.

LLOYD C. HARVIE, M.D. (Saginaw): Mr. Speaker, I would like to thank the men who supported me, and congratulate Dr. Slagle, and assure him of my wholehearted support, and I wish him the best of luck. (Applause).

GEORGE W. SLAGLE, M.D. (Calhoun): Mr. Speaker and delegates, I am deeply grateful. It is with fear and trepidation that I assume and hope to carry out this high honor that you have given me. The shoes that I am expected to fill are tremendous, both literally and figuratively. (Laughter).

I thank you very much, and I hope that I can carry on in the best traditions of the Michigan State Medical Society. Thank you very much for this high honor. (Applause).

THE SPEAKER: At this time we would like to honor the Past Presidents of the Michigan State Medical Society who are present this evening. As I read their names, we would like them to come up and fill this spot right in front of us, and remain there for the rest of the session.

(The Past Presidents in attendance were introduced.)

XIV—8. SPEAKER OF HOUSE OF DELEGATES

THE SPEAKER: The next order of business is the election of a Speaker of the House of Delegates.

C. K. STROUP, M.D.: I nominate the present Vice Speaker, Dr. K. H. Johnson.

J. R. HEIDENREICH, M.D.: I move that nominations be closed and that the Secretary cast the unanimous ballot.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

THE SPEAKER: Dr. Johnson, it is a very nice thing to be able to present to you this piece of jewelry, which says "Speaker of the House of Delegates."

VICE SPEAKER JOHNSON: Thank you, Dr. Livesay. I am sure you will all agree when I say that if I can do half as good a job as Jack Livesay has done during his term as Speaker, I will have done an excellent job.

Thank you very much. (Applause).

XIV—9. VICE SPEAKER OF HOUSE OF DELEGATES

THE SPEAKER: The next order of business is the election of a Vice Speaker of the House of Delegates.

J. B. BLODGETT, M.D.: Mr. Speaker, I would like to nominate for Vice Speaker Dr. James J. Lightbody, of Wayne. Dr. Lightbody is a past president of the Wayne County Medical Society and, by the way, at that time was one of the youngest Presidents. He is a past chairman of our Board of Trustees. He is presently an editor of the *Detroit Medical News,* where he presents his ambivalent personality in the column, "Rant and Rave." He is Medical Director of the Michigan Chapter of the Arthritis and Rheumatism Foundation, and he has been a delegate to this House for the past ten years.

It is a privilege to place his name in nomination.

W. S. REVENO, M.D.: Mr. Speaker, I would like to second the nomination of Dr. Lightbody as Vice Speaker of the House.

F. P. RHOADES, M.D.: I move that nominations be closed and that the unanimous ballot be cast for Jim Lightbody.

The motion was seconded, put to a vote and was carried unanimously.

THE SPEAKER: Dr. Lightbody is elected.

You don't remember it, Jim, but you were the fellow who nominated me. See what you've gotten yourself into! Congratulations. (Applause).

JAMES LIGHTBODY, M.D. (Wayne): Mr. Speaker and members of the House, it is a coincidence, I presume, that Jack is Speaker at a time when I am just being elected as Vice Speaker. I want to say that Jack has done a tremendous job, and deserves all the acclamation that we can possibly give him.

This afternoon I was just a happy, carefree delegate, and now I really have got myself into something (Laughter). I want to assure you that I fully appreciate the responsibility of this job, and I assure the newly elected Speaker of my full co-operation. I hope that I will be able to uphold the dignity of this job and be as unprejudiced as all of the previous Speakers have been.

Thank you very much. (Applause).

THE SPEAKER: It is always hard to express at this time each year the appreciation for all the help that the Speaker has had in making this House of Delegates run smoothly. I refer especially to Dr. Johnson, who has been a tremendous help, and I am sure you are going to have a very loyal servant in Dr. Johnson.

Also, to the staff of the central office; to Dr. Foster, Mr. Burns, Mr. Brenneman, and the secretarial help, not to mention Mrs. Emmons, who sits so calmly through all these long sessions.

I think this has been a successful meeting of our House of Delegates. I was very impressed when Mrs. Emmons, our stenotypist, told me before the session opened this evening that so far seventy-six different doctors have spoken on the floor of the House of Delegates out of around 100. I think that speaks well for democracy in the House of Delegates of the Michigan State Medical Society.

It has been a great pleasure to serve as your Speaker, and I am sure it will be a great pleasure to use some of my leisure time leisurely as well.

XIV—10. COUNCILOR, 3RD DISTRICT

S. A. FIEGEL, M.D.: With the election of Dr. Slagle as President-elect it leaves a vacancy in the Councilorship of the 3rd District.

In his stead I would like to place in nomination a hard worker from the 3rd District, a man who has been a member of the Public Relations Committee since its inception, who has worked very diligently in the 3rd District and in the House of Delegates for any number of years—I can't tell you how many. That man is H. J. Meier, of Coldwater, Branch County.

S. E. ANDREWS, M.D. (Kalamazoo): I would like to second that nomination.

H. C. HANSEN, M.D.: Mr. Speaker, I want to second the nomination of Dr. Meier, also, as a delegate from Calhoun County with my associates, Drs. Hubly and Keagle. It is our unanimous opinion that he should be appointed.

I wish to move to close nominations.

THE SPEAKER: Dr. Hansen moves that nominations be closed and that the Secretary cast the unanimous ballot for Dr. Meier.

The motion was seconded, put to a vote and was carried unanimously.

THE SPEAKER: Dr. Meier, you are the new Councilor from the 3rd District.

This ninety-first session of the House of Delegates stands adjourned.

(The meeting adjourned *sine die* at 10:20 p.m.)

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

Thomas J. Heldt, M.D., Detroit, is the author of an article entitled "Some Historical Reminders in Hospitalization," published in the *Henry Ford Hospital Medical Bulletin,* September, 1956.

W. D. Butt, M.D., Detroit, is the author of an article entitled, "Rigid Wire Fixation of Fractures of the Hand," published in the *Henry Ford Hospital Medical Bulletin,* September, 1956.

George L. Waldbott, M.D., Detroit, is the author of an article entitled, "The Allergic Aspect of Pruritus Ani and Vulvae," published in *GP,* October, 1956.

Andrew H. Veldhuis, M.D., L. A. Swinehart, M.D., and **L. E. Preuss, M.S.,** Detroit, are the authors of an article entitled, "The Use of Radioactive Gold in the Treatment of Cancer of the Cervix," published in the *Henry Ford Hospital Medical Bulletin,* September, 1956.

Brenton M. Hamil, M.D., Detroit, is the author of an article entitled, "Reticuloendotheliosis," published in the *Henry Ford Hospital Medical Bulletin,* September, 1956.

Jack S. Guyton, M.D., Detroit, is the author of an article entitled, "Differential Diagnosis of Collagen Diseases," published in AMA *Archives of Ophthalmology,* October, 1956.

V. Everett Kinsey, Ph.D., Detroit, with the assistance of **June Twomey Jacobus, N.A.,** Detroit, and **F. M. Hemphill, Ph.D.,** Ann Arbor, is the author of an article entitled "Retrolental Fibroplasia," published in AMA *Archives of Ophthalmology,* October, 1956.

Leroy C. Harris, Jr., M.D., John C. Parry, M.D., and **F. E. Greifenstein, M.D.,** Detroit, are the authors of an article entitled "Dyclonine—A New Anesthetic Agent: Clinical Evaluation," published in *Anesthesiology,* September-October, 1956.

Clifford W. Gurney, M.D., and **Robert J. Bolt, M.D.,** Ann Arbor, are the authors of an article entitled "The Simultaneous Use of Chromium Labeled Erythrocytes and I-131 Tagged Human Serum Albumin in Blood Volume Determinations," published in the *University of Michigan Medical Bulletin,* August, 1956.

John V. Verner, Jr., M.D., H. Phil Gross, M.D., and **John M. Weller, M.D.,** Ann Arbor, are the authors of an article entitled "Pneumococcal Meningitis Treated with Hydrocortisone, ACTH, and Antibiotics," published in the *University of Michigan Medical Bulletin,* August, 1956.

Peter A. Martin, M.D., Detroit, is the author of an article entitled "Note on Inhibition of Scientific Productivity," published in the *Psychoanalytic Quarterly,* XXV: 415-417, 1956.

Victor R. Jablokow, M.D., Detroit, and **Robert G. Stineman, M.D.,** Evanston, Illinois, are the authors of an article entitled "Perforation of the Interventricular Septum with Right Bundle Branch Block," published in *American Practitioner and Digest of Treatment,* October, 1956.

John A. Churchill, M.D. and **Salvador Gonzalez, M.D.,** Detroit, are the authors of an article entitled, "The Worth of Serial Electroencephalograms," published in the *Henry Ford Hospital Medical Bulletin,* September, 1956.

E. A. Irvin, M.D., Detroit, is the author of an article entitled "Industrial Placement of the Physically Handicapped," part of the Symposium on Rehabilitation of the Injured Workers presented at the Thirty-third Annual Session of the American Congress of Physical Medicine and Rehabilitation, held in Detroit in August, 1955, and published in the *Archives of Physical Medicine and Rehabilitation,* October, 1956.

Alma J. Murphy, Ph.D., Norman S. Talner, M.D., and **David G. Dickinson, M.D.,** Ann Arbor, are the authors of an article entitled "Glossopharyngeal Breathing in the Management of the Chronic Poliomyelitic Respirator Patient," read at the Thirty-third Annual Session of the American Congress of Physical Medicine and Rehabilitation, held in Detroit in August, 1955, and published in the *Archives of Physical Medicine and Rehabilitation,* October, 1956.

John T. Ferguson, M.D., and **Frank V. Z. Linn, M.D.,** Traverse City, are the authors of an article entitled "A New Compound for the Symptomatic Treatment of Tension and Anxiety: 2-Ethylcrotonylurea (Nostyn)," published in *Antibiotic Medicine and Clinical Therapy,* October, 1956.

Andrew H. Veldhuis, M.D., Laymond A. Swinehart, M.D., Luther E. Preuss, M.S., and **C. Paul Hodgkinson, M.D., F.A.C.S.,** Detroit, are the authors of an article entitled "Experimental Studies on Interstitial Injection of Radioactive Colloidal Gold (AU 198)," published in *Surgery, Gynecology and Obstetrics,* November, 1956.

Capt. Robert W. Gillespie (MC), U.S. Army, Wayne W. Glas, M.D., George H. Mertz, M.D., Eloise, and **Merle M. Musselman, M.D.,** Omaha, are the authors of an article entitled "Richter's Hernia," read at the Thirteenth Annual Meeting of the Central Surgical Association, Rochester, Minnesota, February, 1956, and published in the AMA *Archives of Surgery,* October, 1956.

Joseph L. Posch, M.D., Detroit, is the author of an article entitled "Primary Tenorrhapies and Tendon

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MICHIGAN AUTHORS

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Grafting Procedures in Hand Injuries," read at the Thirteenth Annual Meeting of the Central Surgical Association, Rochester, Minnesota, February, 1956, and published in the AMA *Archives of Surgery,* October, 1956.

M. A. Block, M.D., B. E. Brush, M.D., J. L. Ponka, M.D., and **R. J. Priest, M.D.,** Detroit, are the authors of an article entitled "The Diagnosis of Postcholecystectomy Biliary Tract Stones," read at the Thirteenth Annual Meeting of the Central Surgical Association, Rochester, Minnesota, February, 1956, and published in the AMA *Archives of Surgery,* October, 1956.

John W. Ditzler, M.D. and **Gene McIvor, M.D.,** Detroit, are the authors of an article entitled "Paraplegia Following General Anesthesia," published in *Current Researches in Anesthesia and Analgesia,* September-October, 1956.

Henry T. Johnson, M.D., Lansing, is the author of an article entitled "Meet the Surgeon," published in the Fall, 1956, issue of *Blue Print for Health,* the national Blue Cross health digest. Similar articles by Dr. Johnson about the radiologist, anesthesiologist, and pathologist will follow in subsequent issues.

Jack Lapides, M.D. and **John M. Bobbitt, M.D.,** Ann Arbor, are the authors of an article entitled "Diagnostic Value of Bulbocavernous Reflex," published in the *Journal of the American Medical Association,* November 3, 1956.

Edmund L. Cooper, M.D., Detroit, is the author of an article entitled "Accommodation and Convergence," which was read at the Eastern Regional Meeting of the American Association of Orthoptic Technicians, April, 1955, in Philadelphia, and published in *The American Orthoptic Journal,* Volume 6, 1956.

Elsie H. Laughlin, O.T., Iowa City, Iowa, **Mary Louise Cronin, O.T.,** Rochester, Minnesota, and **Lorraine Lucas, O.T.,** Detroit, are the authors of an article entitled "A Panel Discussion On Small Angle Esotropia," published in *The American Orthoptic Journal,* Volume 6, 1956. This paper was read at the Midwestern Regional Meeting of the American Association of Orthoptic Technicians, May, 1956, in Milwaukee.

* * *

The Michigan Health Council has announced the Tenth Rural Health Conference to be held at the Kellogg Center of Michigan State University at East Lansing. The program will extend over three days, January 16, 17, and 18, 1957. Wednesday will be Professional Day, Thursday, Rural Health Day, and Friday, Community Health Day. For discussion will be fluoridation, sanitation, school health, water supply, "No Doctor in Town," traffic safety, farm accidents, and zoning ordinances.

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Blue Cross and Blue Shield payments continue to set records never before reached. During the first eight months of this year, Michigan Hospital Service paid

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to hospitals for services to its subscribers $66,534,939, an increase of 15.6 per cent over last year. This represents 92.82 per cent of earned income. The cost of operation was 3.785 per cent. During the same period, Michigan Medical Service paid $27,409,063, an increase over last year of 32 per cent. The reason for the M.M.S. increase is that the auto industry has increased x-ray and E.K.G. benefits, plus having mostly the $5,000 contract instead of the $2,500 one. Payments amount to 95 per cent of income, with operation costs 7.71 per cent. If these costs do not level off during the last four months, as they have in the past, some difficult problems will develop.

* * *

Medical Costs Up.—The monthly Consumers Index of the Department of Labor reports medical costs up for the current period. The index for medical care, which includes drugs and hospitalization as well as professional services and other essentials, rose from 133.3 to 134.3. The figures for food, housing, clothing, and other essentials was 117.1, as compared to 116.8 for the preceding month. The Bureau attributes the rise in the index to increased costs of hospital insurance and hospital costs. St. Louis, Missouri, had the highest cost average, 143.6, Detroit followed with 143.3, and Baltimore came next with 143. The index for Philadelphia was 138.1, Cincinnati 137.5, Chicago 136.8, San Francisco 135.5, Atlanta 128.2, New York 127.9, and Los Angeles 127.7.

* * *

AEC Research Awards.—Award of fifty unclassified life science research contracts in the fields of medicine, biology, biophysics and radiation instrumentation was announced by the U. S. Atomic Energy Commission. The contracts were awarded to universities and private institutions as part of the A.E.C.'s continuing policy of assisting and fostering research and development in fields related to atomic energy.

Ten of the awards, each of which covers a period of one year, are new projects; three are in the field of medicine, six in biology, one in radiation instrumentation. Forty contract renewals for one year were awarded to allow for continuation of research already in progress. Nineteen of these are in the medical sciences, sixteen in biology, three in biophysics and two in radiation instrumentation.

Contracts awarded in Michigan are as follows: (1) **University of Michigan:** Henry J. Gomberg, Studies with an X-Ray, Monochromator and X-Ray, Irradiation Service Operation, $20,000; (2) **Wayne University:** James E. Lofstrom, Studies on the Effects of Maternally Administered Phosphorus-32 on Fetal and Post-Natal Development of the Rat, $10,002; and (3) **University of Michigan:** R. E. Potter, The Biological Effects of Radiation, $50,000.

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The survey conducted by the Michigan State Medical Society on State Medical Society dues is cited in the

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Connecticut State Medical Journal for October, on the "Secretary's Office" page. Also listed is the report of amount of dues and special assessments.

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The Kellogg Foundation has established a fund of $100,000 to set up a program to screen foreign medical school graduates seeking internship appointments in the United States. The Co-operating Committee on graduates of foreign medical schools will receive applications and evaluate credentials, and at present plan to conduct screening examinations in English in the applicant's home country through the foreign offices of the Educational Testing Service, Inc. It is hoped to start early in 1957.

* * *

The Seventh Annual County Medical Societies Civil Defense Conference, sponsored by the Council on Civil Defense of the American Medical Association, was held in Chicago, November 10 and 11, 1956. Among the participants were the following from Michigan: **Charles P. Anderson, M.D.,** Detroit; **Jacques Cousin, M.D.,** Dearborn; **Max L. Lichter, M.D.,** Detroit; **Max M. Van Sandt, M.D.,** Battle Creek; and **John M. Whitney, M.D.,** Battle Creek.

* * *

Of all the active cases of tuberculosis reported in 1955, symptoms led to the discovery of 25 per cent. This percentage may be higher since reports on more than 1,000 of the 3,416 total of active cases gave no information on what led to the discovery. Usually when tuberculosis is discovered through symptoms, the disease is in the advanced stages and has been passed to others by the infected person. A chest x-ray should be a part of every routine physical examination.

MICHIGAN TUBERCULOSIS ASSOCIATION

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Members of the Kansas City Society of Anesthesiologists, the Missouri Society of Anesthesiology, and the Kansas Society of Anesthesiology were hosts for the annual meeting of the American Society of Anesthesiologists, held in Kansas City, October 10 to 12. Michigan men presenting papers were **Louis W. Lewis, M.D.,** Ann Arbor, whose topic was "Chemical Rhizotomy In Management of Intractable Pain," and **Ferdinard E. Greifenstein, M.D.,** Detroit, who participated in a panel discussion, his topic being "Anesthesia for Intracardiac Surgery."

* * *

The Mississippi Valley Medical Society held its Twenty-first Annual Meeting at the Hotel Morrison in Chicago, September 26, 27, and 28. Speakers for the scientific program included the following men from Michigan: **H. Marvin Pollard, M.S., M.D., F.A.C.P.,** Ann Arbor, whose topic was "Lower Abdominal Pain;" **Charles G. Johnston, M.D., M.S., F.A.C.S.,** Detroit, whose subject was "Intestinal Obstruction;" and **Dwight C. Ensign, M.D., F.A.C.P.,** Detroit, who participated

in a panel on "Arthritis and Rheumatic Disease (Medical Treatment and Investigation)."

* * *

William B. Hubbard, M.D. and **William C. Hubbard, M.D.,** Flint, presented a paper entitled "Three New Eye Instruments," at the recent meeting of the Academy of Ophthalmology and Otolaryngology in Chicago.

* * *

The International Academy of Proctology announces its annual cash prize and Certificate of Merit Award Contest for 1956-1957. The best unpublished contribution on proctology or allied subjects will be awarded $100.00 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit. This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contribution will be selected by a board of impartial judges, and all decisions are final.

The formal award of the first prize, and presentation of other certificates, will be made at the annual convention dinner dance of the International Academy of Proctology, May 2, 1957, at The Plaza, New York, New York.

The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, *The American Journal of Proctology*. All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than February 1, 1957, and should be addressed to the International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York.

* * *

New Schering Award Contest.—Three increasingly important branches of medicine—cardiology, mental disease, and the treatment of eye disorders—have been selected as topics for the 1957 Schering Award Contest, according to Award Committee Chairman, Dr. Chester B. Szmal. Dr. Szmal has announced that the new contest is now under way.

The competition, which is open annually to all medical students in the United States and Canada, invites them to submit papers on three topics of current medical significance. The three subjects for 1957 are: (1) Incidence of Various Types of Cardiovascular Diseases by Age Group in the Male and the Female; (2) Recent Trends in Corticosteroid Therapy for Ocular Disorders; and (3) Recent Advances in the Biochemical Aspects and Treatment of Mental Disease.

Literature and entry forms are being distributed in medical schools. Students interested in participating should submit their entry forms by January 1, 1957.

* * *

Virus Disease Simulating Poliomyelitis.—Many cases reported as nonparalytic poliomyelitis may not be polio at all, says a University of Michigan pediatrician. James L. Wilson, M.D., reports that "For years it has been known that a disease caused by the coxsackie virus has all of the symptoms and diagnostic indications of polio, except paralysis."

Chairman of the University department of pediatrics and communicable diseases, Dr. Wilson notes that two cases reported recently as nonparalytic polio at University Hospital were not polio at all, but the coxsackie virus disease. "Extensive laboratory facilities and much time are needed by a hospital to distinguish between these two diseases," Dr. Wilson emphasizes.

Many published reports of new cases of nonparalytic polio indicate that the individual had received one or two shots of the Salk vaccine. "This does not imply in any way that the vaccine shots were at fault in not protecting the person from polio," Dr. Wilson asserts. He adds:

"It should be remembered the 1954 vaccine evaluation report did not credit the vaccine with preventing polio altogether. The report stated that the study indicated that the vaccine's effectiveness lay in its ability to reduce by a very high percentage the incidence of paralytic polio.

"Recent reports of the U. S. Public Health Service continue to substantiate this. They indicate that there has not been one death from paralytic polio during 1956 reported in a person inoculated with three Salk polio shots in the prescribed manner. In both Michigan's 1956 paralytic polio report, and that of Chicago's epidemic, not one case of paralytic polio had occurred among those receiving the three shots."

He suggests that people who have had one or two shots of the vaccine, and later develop nonparalytic polio, very likely have been saved from paralysis by antibodies derived from the vaccine. "Even in cases where mild paralysis occurs in a patient who has had one or two shots, it is probable that the limited amount of vaccine received prevented advanced paralysis."

* * *

Neurologic and Psychiatric Lectures.—Michigan's year-old Lafayette Clinic, training and research headquarters of mental illness, and Wayne State University's College of Medicine are offering postgraduate programs in psychiatry and neurology this fall. Leading psychiatrists from all over the United States will lecture at the psychiatry meetings held on the first and third Fridays of each month from 2 to 5 p.m. Both programs conclude June 21 and 22, 1957.

Both neurology and psychiatry sessions are open to physicians with no fee for the courses. The neurology sessions, scheduled for Saturday mornings from 9 to 12 noon, will review basic and clinical neurology. Psychiatry programs are divided into two sessions. The first part is a case conference with guest participants, followed by the visiting lecturer discussing his specialization.

* * *

The Department of Commerce has licensed the export of 7 million cubic centimeters of poliomyelitis vaccine for the fourth quarter of 1956. During the third quarter the amount was 1.4 million.

* * *

New "highs" have been registered for factory, nonfarm, and total employment. Personal income is up about 7 per cent compared with a year ago. Average factory pay in September was $2.00 per hour. Nonfarm employment was over 52,000,000, and total employment over 66,000,000.

Health Benefits after Age Sixty-Five.—A comprehensive report published Oct. 19, by the U. S. Department of Labor on coverage of older workers under collectively bargained health and insurance plans states that very few of them are discriminatory; in fact, that of 300 plans analyzed—covering some 5 million workers—only three discontinued one or more benefits at age sixty-five or older.

* * *

American Board of Obstetrics and Gynecology.—The next scheduled examinations (Part I), written, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 1, 1957, at 2:00 p.m. Candidates must submit case reports to the office of the Secretary within thirty days of being notified of their eligibility to Part I. The cases must be prepared in the manner described in the Bulletin of the Board with a duplicate index list.

Requests for re-examination in Part II must be received prior to February 1, 1957.

Current bulletins outlining present requirements may be obtained by writing to: Robert L. Faulkner, M.D., Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

The Sixth Annual Symposium on Blood will be held at Wayne State University, Detroit, on January 18 and 19, 1957. Beginning at 9 a.m., papers will be presented all day Friday in the auditorium of the College of Medicine, 645 Mullett Street. Facilities for a group dinner and social gathering are being reserved for Friday evening at a Detroit restaurant famous for fine food. The scientific program will be concluded Saturday noon. Ample time is being allowed for the audience to discuss the contributions of the invited speakers. Walter H. Seegers, Ph.D., Sc.D., is chairman.

* * *

Hospital Benefits.—The American Medical Association has announced a study to determine what the hospital patient gets for his money. It will be the second phase of a five-year study measuring the medical service given the American people by their physicians. The total cost will be about $100,000 and is intended to measure services and not money spent. The results to be published in 1958 may bring about changes in hospital construction, medical education, health insurance rates or scope and other health matters. As a first step, questionnaires have been mailed to 7,000 hospitals to learn the age, sex, length of stay and diagnosis for every hospitalized person discharged during the third week of October, 1956.

It is hoped to determine what ailments or conditions are sending most Americans to the hospial, which are keeping them there longest, and how many beds are taken up by accidents, pregnant women, and non-emergency surgery.

* * *

Michigan Department of Social Welfare.—The *Grand Rapids Press* of October 17, 1956, reports the appointment by Governor Williams of Miss Clara Sweiczkows-

ka of Detroit, to the Board of the Michigan Department of Social Welfare to replace **L. G. Christian, M.D.**, of Lansing, who has served the Board for seventeen years.

* * *

The Frank H. Lahey Memorial Award for distinguished service to medical education by a layman was awarded this year to Colby M. Chester, honorary chairman of the General Foods Corporation. The presentation was made by former President Herbert Hoover at a dinner in Mr. Chester's honor at the Waldorf in New York. Among the speakers who paid tribute to Mr. Chester were Dr. Ward Darley, president of the University of Colorado, who in January will become executive director of the Association of American Medical Colleges.

This is particularly interesting to Michigan, the home of General Foods.

* * *

A radiologist's interpretative knowledge of the shadows on an x-ray film has dramatically led to the return of an infant to its rightful parents after they innocently had taken home the wrong baby from the hospital.

That is the story told in the September, 1956, issue of *Radiology* by a Hagerstown, Maryland, radiologist, Dr. Stanley H. Macht. In relating the experience, with its happy ending, Dr. Macht pointed out in his article that there are occasional reports these days of "mix-ups" among newborn infants in busy hospital nurseries.

* * *

James L. Wilson, M.D., chairman of the University of Michigan's Department of Pediatrics and Communicable Diseases, told a meeting of the Omaha-Midwest Clinical Society that newborn infants might soon be getting "quadruple" shots, including the Salk vaccine, to protect them against major diseases. Three-month-old youngsters are now getting two shots—polio vaccine and a triple vaccine for protection against diphtheria, tetanus and whooping cough—at the University of Michigan Medical Center Well Baby Clinic.

"This is just the first step," Dr. Wilson said. "At the present time, we are using two syringes and two needles. We hope to demonstrate soon that both polio vaccine and triple vaccine can be effectively put together and injected into the child, using only one syringe. We have every reason to believe that this will be successful."

* * *

Lectures on History of Surgery.—The International College of Surgeons through its School of the History of Surgery and Related Subjects has inaugurated a series of lectures on the history of surgery. They will be presented in the Surgeons Hall of Fame, 1524 Lake Shore Drive, Chicago, and are open to physicians and medical students, according to Dr. Max Thorek, international secretary-general.

Dr. Leo M. Zimmerman, secretary-treasurer of the Society of Medical History of Chicago and professor and chairman of the department of surgery, Chicago Medical School, gave the first lecture on October 23. Dr. Zimmerman's subject was "Beginning of Surgery and Edwin Smith Papyrus."

(Continued on Page 1556)

(Continued from Page 1554)

Other lectures in the series will be:

January 8—"Early French Surgery," Dr. Guy Kasten Tallmadge, professor of the History of Medicine, Marquette University School of Medicine, Milwaukee.

January 29—"Surgeons and the Rise of Anatomy," Dr. Ilza Veith, professor of the history of medicine, University of Chicago, and president of the Chicago Society of Medical History.

February 19—"Antisepsis and Asepsis," Dr. Eugene M. K. Geiling, Frank B. Hixson Distinguished Service professor and chairman of the department of pharmacology, University of Chicago.

March 1—"The Development of Surgical Anesthesia" Dr. Max Sadove, professor of anesthesiology, University of Illinois.

April 2—"British Anatomists and Surgeons," Dr. Lloyd G. Stevenson, professor of the history of medicine, McGill University, Montreal.

April 23—"Barber Surgeons and the Liberation of Surgery," Dr. Morris Fishbein, professor of medicine (Rush) University of Illinois College of Medicine, Chicago.

May 14—"The Rise of Modern Surgery," Dr. Chauncey Leake, College of Medicine, Ohio State University, Columbus.

* * *

New Brochure on Medical Internships.—Major-General Silas B. Hays, the Surgeon General of the Army, addressing recently graduated doctors of medicine announce a new brochure on the Army Medical Intern Program.

Young doctors concerned with a decision as to where they will intern will find a well-rounded résumé of fundamental information in the illustrated pamphlet entitled, "An Army Internship of Superior Training." The booklet carries a map of the United States showing the location of the Army's seven teaching hospitals on the continent, the eighth, Tripler Army Hospital, is in Hawaii.

Copies of the new brochure may be obtained from the following distribution points: Army Medical Service Procurement Officer, Medical Section, Headquarters, First Army, Governors Island, New York; Army Medical Service Procurement Officers, Medical Section Headquarters, Second Army, Fort George G. Meade, Maryland; Army Medical Service Procurement Officer, AG Section Headquarters, Third Army, Fort McPherson, Georgia; Army Medical Service Procurement Officer, Medical Section, Headquarters, Fourth Army, Fort Sam Houston, Texas; Army Medical Service Procurement Officer, Military Personnel Procurement Division, Headquarters, Fifth Army, 1660 East Hyde Park Blvd., Chicago, Illinois; and Army Medical Service Procurement Officer, Medical Section, Headquarters, Sixth Army, the Presidio of San Francisco, California.

* * *

Laurence F. Segar, M.D., Detroit, has been appointed Governor for the State of Michigan of the American Diabetes Association for the year 1956-57.

* * *

William A. Hyland, M.D., Chairman of the AMA Delegates from Michigan, was appointed Chairman

of the Reference Committee on Medical Education and Hospitals at the Seattle AMA Annual Session.

* * *

The Wayne County Medical Society broke ground for its new building, December 1, 1956. The new building will be erected next to the Medical Library of Wayne State University College of Medicine, Detroit.

* * *

D. Bruce Wiley, M.D., of Utica, Chairman of The Council of the Michigan State Medical Society, was guest speaker at the meeting of the Southeastern District of the Woman's Auxiliary (seven counties) in Mt. Clemens, November 5. His subject was: "Problems Facing the Michigan State Medical Society."

* * *

"The Doctor in the Law—Fundamentals" is an interesting and informative booklet published by the Law Department of the Medical Protective Company, Fort Wayne, Indiana. "Fundamentals" is the first in a series of such booklets. Selected legal doctrines will be discussed in succeeding issues.

* * *

The Barry County Medical Society recently contributed $5,000 to the Michigan Foundation for Medical and Health Education to be earmarked for the purpose of loans to medical students, residents of Barry County, under the terms of the Student Aid Revolving Fund Plan administered by the Foundation.

This oustanding generosity will aid in a very material sense young medical students or residents of Barry County who are being educated at either Wayne State University College of Medicine or the University of Michigan Medical School.

Congratulations, Barry County, on this enlightened action!

* * *

Frank E. Luton, M.D., formerly of St. Johns, Michigan, has been appointed physician of Beaver Island effective November 1. Dr. Luton will replace Harry F. Vail, M.D., who returned to the mainland September 1, to resume private practice. Dr. Vail had practiced on the Island since 1952.

Dr. Luton has practiced in St. Johns for the last thirty-nine years. He was former Chief of Staff of Clinton Memorial Hospital in St. Johns and is an Emeritus Member of the Michigan State Medical Society.

* * *

The American Association of Medical Assistants held its first National Convention in Milwaukee, Wisconsin at the Pfister Hotel, October 26, 27 and 28; Alice Budny of Milwaukee was General Chairman.

Hallie Cummins of Caro, Michigan, immediate Past President of the Michigan State Medical Assistants Society, was selected by a Michigan-Indiana caucus as delegate to the National Board of Directors. She was elected by the Board of Directors as chairman of the three-member Executive Committee.

Two hundred and forty medical assistants, representing sixteen states, drafted and adopted a constitution

and By-Laws, and elected officers for this, the first year of the American Association of Medical Assistants. The officers: President—Maxine Williams, Kansas; Treasurer—Carmen Kline, Kansas; Vice President—Marion Little, Iowa; President-Elect—Mary Kinn, California; Recording Secretary—Alice Budny, Wisconsin.

Representatives of the AMA and Medical Society Advisory Board members were there to assist in the initial planning of the organization. Ralph W. Shook, M.D., Kalamazoo, Vice Chairman of the Advisory Committee to the MSMAS, attended in an advisory capacity. J. E. Manning, M.D., Saginaw, was the Saturday evening banquet speaker; his subject, "The Ideal Medical Assistant." Accompanying Miss Cummins in the nineteen-member Michigan delegation were: Lorine Nuechterlein, Saginaw, official representative of the MSMAS; Doris Jarrad, Lansing, President of MSMAS, Mrs. Lila Angel, Mrs. Charlotte Ash, and Mrs. Harriet Rolph, Kalamazoo; Josephine Anthony, Mrs. Marianne Baughman, Mary Daigle and Donna Hislop, Muskegon; Miss Janice Lupien of Muskegon Heights; Mrs. Vivian Branyan of Grand Haven; Miss Gloria Conklin and Mrs. Marie Erickson of Saginaw, Mrs. Violet Howorth and Mrs. Margaret McKay of Benton Harbor and Miss Helen Rehm of Ferndale; Mrs. Eileen DeWent of Holland and Mr. Kenneth Cook of Saulte Ste. Marie, Michigan.

Officers elected for the coming year are: President—Doris Jarrad, Lansing; President-Elect—Marlouise Redman, Detroit; Recording Secretary—Arlene Bublitz, Bay City; Corresponding Secretary—Dorothy Little, Lansing; Treasurer—Alberta Warmbold, Paw Paw.

WHAT THEY SAID ABOUT THE 1956 MSMS ANNUAL SESSION

Somers H. Sturgis, M.D., Boston (guest essayist): "It was indeed a rewarding experience for all of us who attended."

Lester S. Reavley, M.D., Sterling, Illinois (President Elect of Illinois State Medical Society): "Mrs. Reavley and I shall always have many pleasant memories of our trip to the Michigan meeting of 1956."

L. O. Simenstad, M.D., Osceola, Wisconsin (President of the State Medical Society of Wisconsin): "I have never enjoyed a meeting more. I thought you were all most considerate."

Otis Anderson, M.D., Washington, D. C. (guest essayist): "I wish to express my appreciation for the generous hospitality I enjoyed during my attendance at the MSMS annual meeting."

M.D. LOCATIONS

Through November 1, 1956

Placed by Michigan Health Council

Richard G. Hopkins, M.D.....Elk Rapids (Nov. 1)

Assisted by Michigan Health Council

Robert C. Hafford, M.D. .....Bay City
Alexandre Lusis, M.D. .....Mount Pleasant
Robert O. Dubpernell, M.D. .....Detroit
William L. Farmer, M.D.....Detroit
A. S. Lightfoot, M.D. .....Flint

Mount Carmel Mercy Hospital's Annual Clinic Day will be held Wednesday, January 30, 1957. The program has been set up as follows:

Morning Session—9:00 a.m.

I. C. RUBIN, M.D.,
Emeritus Professor of Clinical Gynecology,
New York University, New York.
"The Role of Fibroids in Infertility With Special Reference to Myomectomy"

WALTER C. ALVAREZ, M.D.,
Emeritus Professor of Medicine, Mayo Clinic,
Rochester, Minnesota.
"The Neuroses and The Minor Psychoses"

BURRILL B. CROHN, M.D.,
Distinguished Gastroenterological Consultant,
Columbia University, New York, New York.
"Diagnosis and Treatment of Regional Ileitis"

CHARLES F. GESCHICKTER, M.D.,
Professor of Pathology, Georgetown University,
Washington, D. C.
"Benign and Malignant Lesions of the Breast"

Luncheon—12:30 p.m.

Compliments of the Sisters of Mercy.

Afternoon Session—1:45 p.m.

LEO G. RIGLER, M.D.,
Professor and Chief of Department of Radiology,
University of Minnesota, Minneapolis, Minnesota.
"The Detection of Disease in Its Incipiency"

ANGUS D. McLACHLIN, M.D.,
Professor of Surgery and Chairman, Department of Surgery,
University of Western Ontario, London, Canada.
"The Surgical Management of the Diabetic Foot"

RICHARD H. OVERHOLT, M.D.,
Clinical Professor of Surgery,
Tufts University, Boston, Massachusetts.
"The Direct Approach to Shadow and Substance"

* * *

The Department of Postgraduate Medicine, University of Michigan Medical School, announces brief review courses for practicing physicians in 1957 as follows:

Anatomy .....(Thursdays) February 7-May 23
Basic Sciences .....October 1-June 1
Clinical Exercises for Practitioners
.....(Wednesdays) October 10-May 15
Internal Medicine
Clinical Internal Medicine
.....(Thursdays) October 4-April 18
Diseases of the Heart .....March 18-22
Electrocardiographic Diagnosis .....March 25-30
Metabolism and Endocrinology .....April 1-5
Diseases of the Blood and Blood-Forming Organs .....April 8-12
Diseases of Gastrointestinal Tract.....April 15-19
Rheumatology .....April 22, 23 and 24
Pulmonary Diseases .....April 25, 26 and 27
Recent Advances in Therapeutics.....April 29-May 3
Ophthalmology .....April 22, 23 and 24
Otolaryngology .....April 18, 19 and 20
Pediatrics—Obstetrics and Gynecology .....January 28-February 1
Radiology, Diagnostic .....April 8-12
Radio-active Isotopes, Clinical use of.....As arranged

Further information and application blanks may be obtained from: John M. Sheldon, M.D., Director, Department of Postgraduate Medicine, 1610 University Hospital, Ann Arbor, Michigan.

MEDICAL TELEVISION SHOWS
Produced by Michigan Health Council

Date	*Station*	*Subject*	*Guests*
Oct. 7, 1956	WJBK-TV, Detroit	"Tuberculosis"	Miss Minetta Nicolai, Lansing Oscar D. Stryker, M.D., Mt. Clemens
Oct. 11, 1956	*WKAR-TV, East Lansing*	"Sanitation"	Robert Forbes, Detroit
Oct. 14, 1956	WJBK-TV, Detroit	"Safe Plumbing—Good Health"	Philip Shirley, Lansing Robert Lyons, Lansing Gray Turney, Lansing
Oct. 21, 1956	WJBK-TV, Detroit	"Wayne County Area Regional Health Conference"	A. Jerome Geisler, Dearborn Wilbur White, Detroit Edwin Walker, River Rouge Francis M. Schmitt, DDS, Garden City James Charters, Dearborn
Oct. 25, 1956	*WKAR-TV, East Lansing*	"Foot Health and the Chiropodist"	J. E. Snyder, DSC, East Lansing William E. Sackett, DSC, Lansing
Oct. 28, 1956	WJBK-TV, Detroit	"Alcoholism in Michigan"	Miss Ruth Segall, Ypsilanti Roland Athay, M.D., Detroit George Nimmo, Lansing

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SURGERY OF THE HAND. By Sterling Bunnell, M.D., Honorary Member, American Academy of Orthopedic Surgeons, American Orthopaedic Association, Western Orthopedic Association, California Society of Plastic Surgeons, and Sociodad Latino-Americana de Ortopedia y Traumatologia; Corresponding Member, British Orthopaedic Association; Foreign Corresponding Member, Societas Ortopedica Scandinavica; Member, American Surgical Association, American Association of Plastic Surgeons, American Society of Plastic and Reconstructive Surgery, American Association for the Surgery of Trauma, and American Society for Surgery of the Hand; Emeritus Member, Hand Club of Great Britain; Fellow, American Occupational Therapy Association (1951-1953); Consultant to the Surgeon General of U. S. Army, to the U. S. Navy, and to the Alaska Department of Health; U. S. Medal for Merit; Ordre National de la Le'gion d'Honneur; Ordem Nacional do Cruzeiro do Sul; Licentiate, American Boards of General, Plastic and Orthopaedic Surgery. Third Edition, 1047 illustrations and nine color plates. Philadelphia and Montreal: J. B. Lippincott Company. Price $22.50.

Doctor Bunnell and his associates have rewritten and enlarged the new third edition of this outstanding reference on acute and chronic injuries of the hand, adding 200 new photographs and illustrations. The changes and new features will be of considerable help to the surgeon who is confronted by the new problems which result from the trauma of increasingly complex machinery and automation.

There are additions to the chapters on skin grafting and plastic surgery, the use of antibiotics, new splinting techniques and recent ideas on early exercise following surgery. Causalgia and painful amputation stumps are well discussed in the light of new procedures. The subject of nerve grafting has been amplified, as well as the immediate suture of severed nerves, large and small. There are new procedures on thumb reconstruction and the construction of new digits. The final chapter on tumors of the hand has been amplified in subject and new photographs added.

An important part of hospital, teaching and private medical libraries since 1944, his new third edition will continue to aid the surgeon produce a better result.

S.B.W.

ORGANIZED HOME MEDICAL CARE IN NEW YORK CITY. A Study of Nineteen Programs. By The Hospital Council of Greater New York. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956. Price $8.00.

The Hospital Council of Greater New York has conducted a study of nineteen medical home care programs in and about New York City. This has been going on for years and reports have been issued in Pamphlet form covering certain phases.

This book consolidates the work and makes a vast

amount of material available. After outlining the scope, objectives and methods of study, a review of the history and background is made. An extensive and critical study of the patients and their families follows with chapters on home care, diagnosis, length of stay, types of service, attitudes of the patients and their families. This is followed by a comparison of the various types of program and experience.

The analysis covers the objectives, personnel, referral, acceptance and rejection of patients, administration of service, relationship to hospitals and evaluation. Ideal programs are suggested.

The appendices contain reports from Montefiore Hospital and fourteen municipal and tuberculosis hospitals dealing with chronic case care.

The book contains a wealth of information valuable in medical case studies.

EDUCATING SPASTIC CHILDREN. The Education and Guidance of the Cerebral Palsied. F. Eleanor Schonell, M.A., Ph.D., Formerly Research Fellow, University of Birmingham, Department of Pediatrics and Child Health. New York: Philosophical Library. Price $6.00.

This is a field which has been sadly neglected but for unusual efforts mostly in individual cases. The reviewer knows a severely spastic boy who secured a good education and became a successful lawyer. Opportunities had to be made, but they were available. This book is most encouraging and challenging and we bespeak wide use.

It reviews historical interest and stresses the recognition and estimation of intelligence as a first requisite, then building upon every opening and even making every opening.

Twenty-four per cent of these children are normal or supernormal in intelligence, as against 73 per cent of the normal population.

COMMUNITY PROGRAMS FOR MENTAL HEALTH. Theory—Practice—Evaluation. Editors: Ruth Kotinsky and Helen L. Witmer. Advisory Committee: Abraham Z. Barhash, M.D.; Jules V. Coleman, M.D.; Sibylle Escalona; Katherine E. Faville; George E. Gardner, M.D.; Paul V. Lemkau, M.D.; W. Carson Ryan; and Mildred C. Scoville. Contributors: Barbara Biber; H. E. Chamberlain; Sol W. Ginsburg; Robert R. Holt; Louisa P. Howe; Marie Jahoda; Elizabeth de Schweinitz; and Edith Miller Tufts. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1955.

Since its beginning nearly fifty years ago, the mental hygiene movement has undergone many changes, and the field of mental health promotion has become so broad that some appraisal seemed necessary. This compendium endeavors to evaluate what is being done in the name of mental health on a community level. Among the problems discussed is the confusion that arises when a clearly expressed and well delimited definition of "mental health" is attempted. This becomes more difficult when it becomes apparent that the definition must meet the demands of the clinical psychiatrist

and the research scientist, as well as the worker at the community level. Among the criteria presented in definitions of mental health in this book are the following: (1) "the ability to hold a job, have a family, keep out of trouble with the law, and enjoy the usual opportunities for pleasure;" (2) "the absence of mental disease, normality of behavior, adjustment to environment, unity of personality, and correct perception of reality."

The first of these is admittedly "non-scientific" but still does provide a reasonable basis for evaluation. Though the second is somewhat more inclusive, it raises a number of obvious questions as well as the need for further definition. The original effort of the mental hygiene movement was directed at improvement of the services and treatment facilities for mentally and emotionally ill persons. It is a well known fact that this task is not complete. The related problem of education of the general public in regard to the unqualified acceptance of the discharged patient into his original environment also needs further attention. The separation of these objectives from actual "prevention" of mental illness presents further problems confronting the workers at all levels.

In this book all of these problems and questions are presented and discussed in papers under the following titles: "The Mental Health Movement: Its Theoretical Assumptions;" "The Field of Mental Health Promotion;" "Nine Programs for the Promotion of Mental Health;" "Schooling as an Influence in Developing Healthy Personality;" "Problems in the Evaluation of Mental Health Programs;" "Toward a Social Psychology of Mental Health;" and "Problems in the Use of Sample Surveys."

Though no miraculous or far-reaching solutions are presented, this book should be of value to those working in the field of mental health.

OBSERVATIONS ON KREBIOZEN IN THE MANAGEMENT OF CANCER. By A. C. Ivy, Ph.D., M.D., Professor of Physiology and Head of the Department of Clinical Science, University of Illinois, and formerly Executive Director of the National Advisory Cancer Council and Director-at-large of the American Cancer Society; John F. Pick, S.B., M.M., M.D., Head of Department of Plastic Surgery, Columbus Hospital, Chicago, and formerly Assistant Clinical Professor of Surgery, University of Illinois; and W. F. P. Phillips, M.D., Department of General Practice, St. Francis Hospital, Evanston, Illinois. Chicago: Henry Regnery Company, 1956. Price $2.50.

The appearance of this thin book undoubtedly comes as a surprise to those experienced oncologists and cancer workers who felt that, after the thorough study and evaluation of Krebiozen in many quarters, the matter had been corrected and promptly interred for all time.

While the book is heavily weighted with efforts to give the drug better than an even break, there is evidence of considerable candor and the once extravagent claims for cures have now been so modified that its palliative and oncolytic properties are stressed. In a somewhat clouded fashion there is an attempt to relate its action to the present day use of steroid and polysaccharide therapy in neoplastic diseases.

The histopathologic descriptions of tumor types often lead one to question the degree of malignancy, or possibly even the existence of it. The medical reader also will sense a lay approach in the general assembly of the monograph, the manner in which the case reports are presented, and the stubborn chauvinism born of a lost cause. A.A.H.

CLINICAL CHEMISTRY. Principles and Procedures. By Joseph S. Annino, Clinical Chemist, Massachusetts Memorial Hospitals, Boston, Massachusetts. Boston and Toronto: Little, Brown and Company. Price $7.50.

This book is written in a simple lucid style and is ideal for the teaching of clinical chemistry to medical technologists. No words are wasted but the explanations appear adequate. Very little clinical data are included. A.A.H.

THE MENNINGER STORY. By Walker Winslow. Garden City, New York: Doubleday & Company, Inc., 1956. Price $5.00.

In the field of psychiatric medicine, the accomplishments of Dr. Charles F. Menninger and his two sons, Karl and William, must have a very considerable place. This book is, in effect, a biography of these three giants in medical history. It is most interesting reading, going into great detail about the training and many accomplishments of each. The family history is just as interestingly told. We enjoyed the book.

PEDIATRICS. Edited by Donald Paterson, M.D., Formerly Clinical Professor, Department of Pediatrics, The University of British Columbia, and John Ferguson McCreary, M.D., Professor and Head, Department of Pediatrics, The University of British Columbia. With 36 Contributing Authors. Philadelphia. Montreal: J. B. Lippincott Company. Price $14.00.

This excellent text on pediatrics is written for the general practitioner. There are thirty-six contributing authors with very little reduplication of the text material. Emphasis is placed on diagnosis and treatment. The therapy is conservative and possibly behind the present U. S. standards.

The simplified explanation of the pathogenesis of the metabolic and blood diseases is very well done. This book would serve well as text for teaching pediatrics to general practitioners and nurses. The tables on diets, drug dosage and laboratory standards are all excellent.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty.

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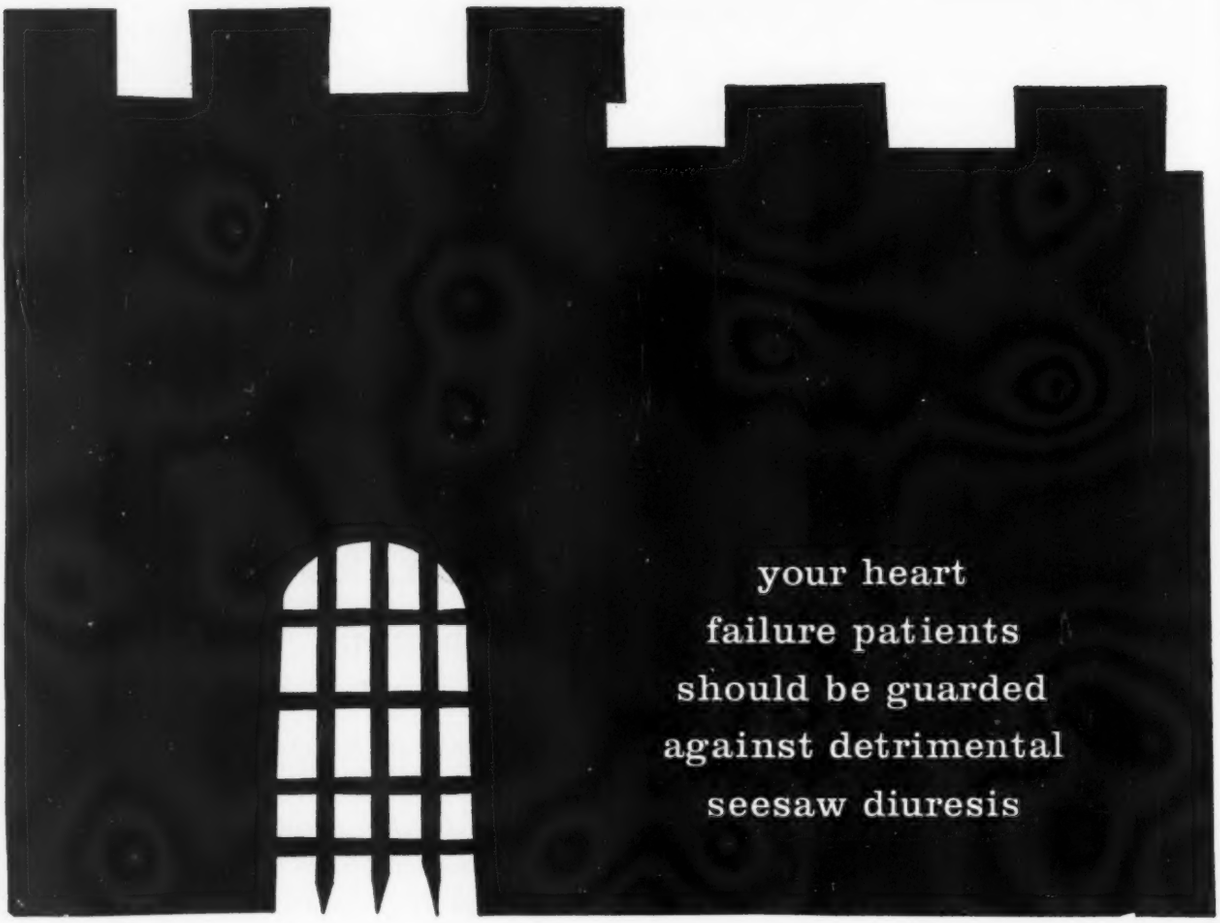

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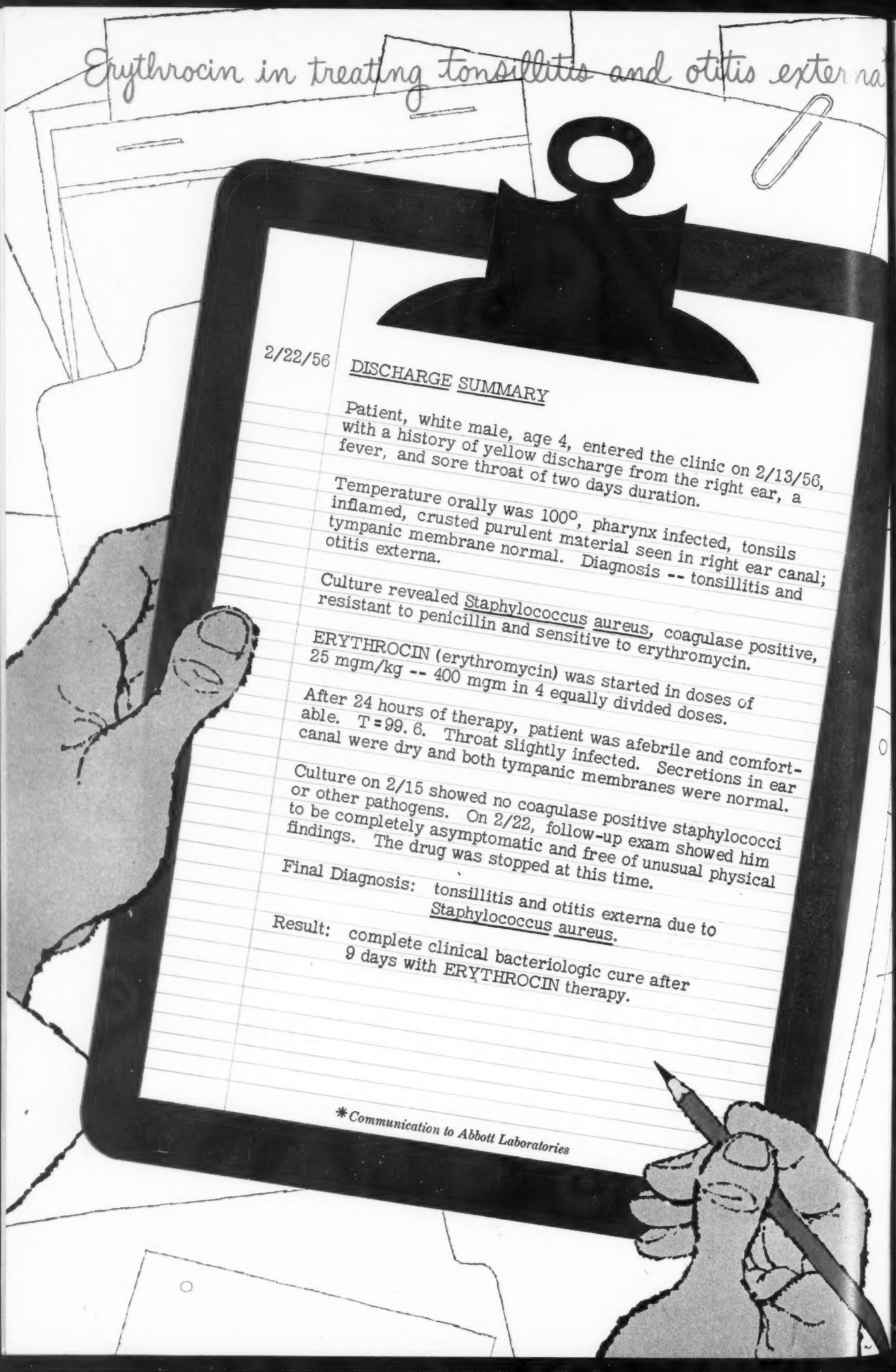
Erythrocin in treating tonsillitis and otitis externa
2/22/56
DISCHARGE SUMMARY
Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.
Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.
Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.
ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.
After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.
Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.
Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.
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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

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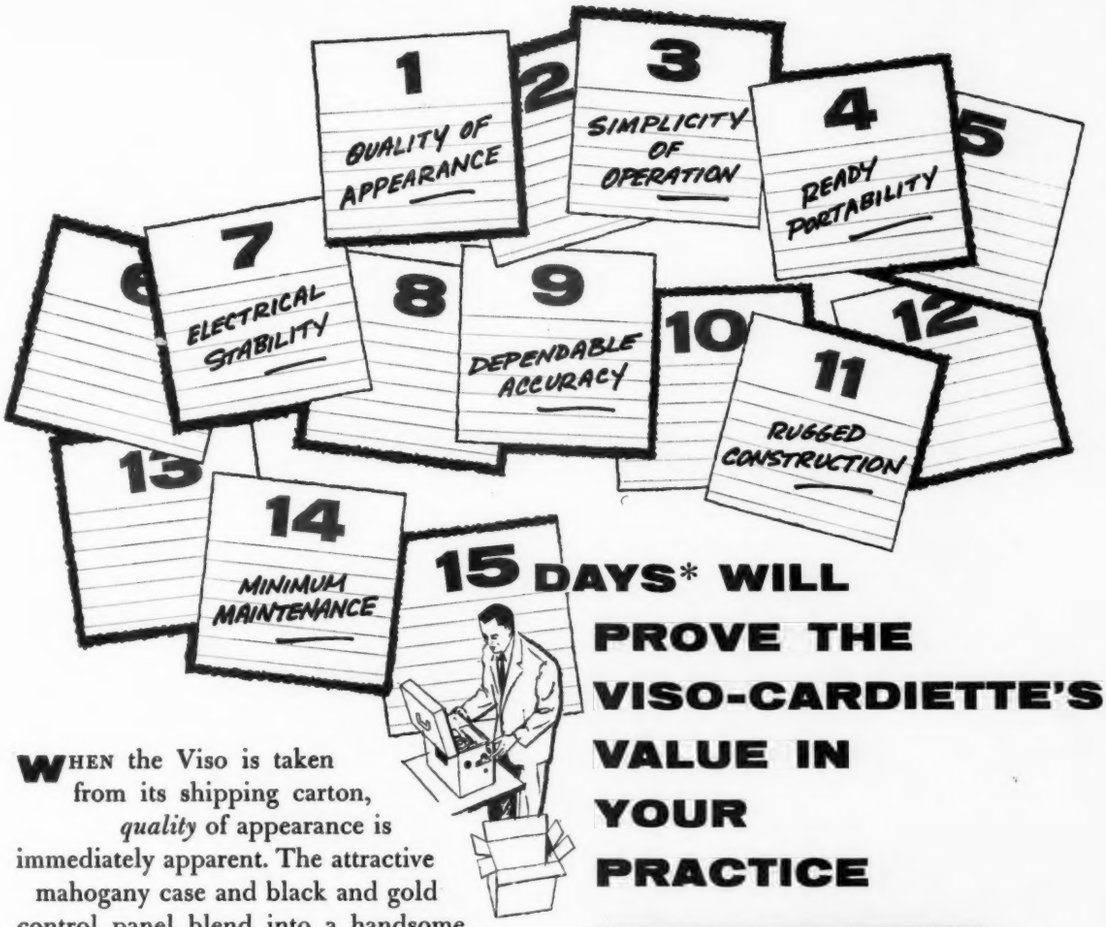

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I'm on my
feet all da
but it was
my arms th
bothered n

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Thursday, January 17, 1957, 9:30 A.M. to 5:00 P.M.
Hall of Mirrors, The Netherland Hilton, Cincinnati, Ohio

PROGRAM

Johnson McGuire, Professor of Clinical Medicine and Director of Cardiac Laboratory, University of Cincinnati College of Medicine, will serve as moderator for the Symposium

K. J. Franklin, The Medical College of St. Bartholomews Hospital, London.
INVESTIGATION OF WHAT IS CONSIDERED NORMAL FOR THE AGING CARDIOVASCULAR SYSTEM

J. Earle Estes, Jr., Mayo Clinic, Rochester, Minnesota.
VENOUS DISORDERS IN OLDER PEOPLE

Walter S. Priest, Associate Professor of Medicine, Northwestern University School of Medicine, Chicago.
ANTICIPATION AND MANAGEMENT OF CARDIAC DECOMPENSATION

Jessie Marmorston, Professor of Experimental Medicine, University of Southern California, Los Angeles.
HORMONAL ASPECTS OF MYOCARDIAL INFARCTION IN FEMALE AND MALE SUBJECTS

Ancel Keys, Professor of Physiology and Director of Laboratory of Physiological Hygiene, University of Minnesota, Minneapolis.
CALORIES AND CHOLESTEROL

Robert W. Wilkins, Professor of Medicine, Boston University School of Medicine, Boston.
DRUG THERAPY FOR HYPERTENSIVE VASCULAR DISEASE IN PATIENTS PAST MIDLIFE

Robert A. Bruce, Associate Professor of Medicine, University of Washington School of Medicine, Seattle.
EVALUATION OF FUNCTIONAL CAPACITY IN PATIENTS WITH CARDIOVASCULAR DISEASE

Edward J. Stieglitz, Consultant in Geriatrics, Veterans Administration and St. Elizabeths Hospital, Washington, D. C.
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References:
1. Finland, M., *et al.: J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.: idem* 4:441 (April) 1954.

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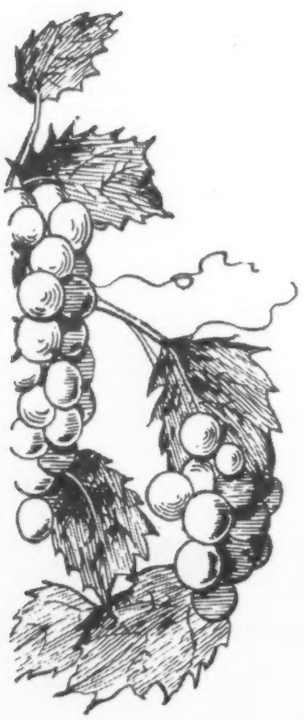

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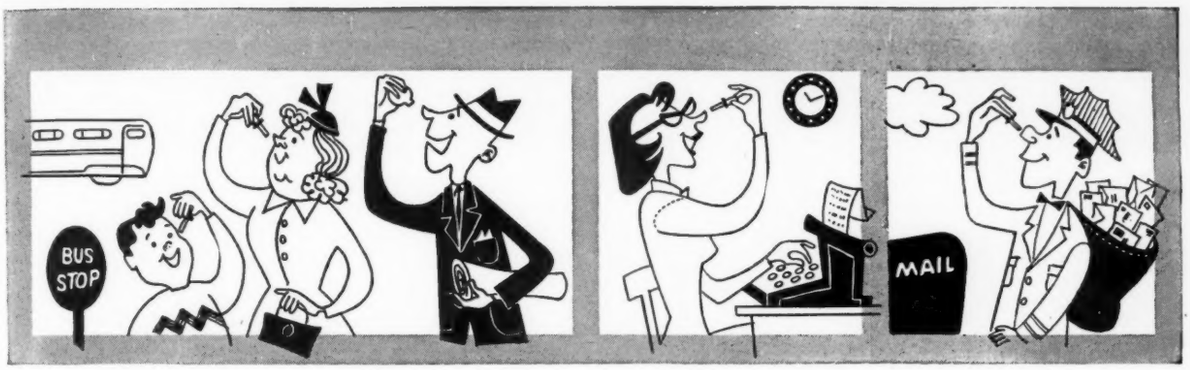

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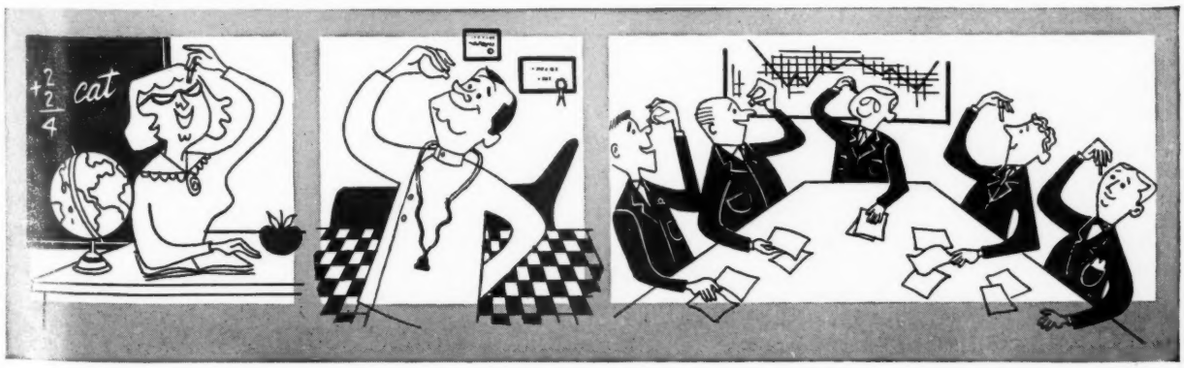

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